REQUEST FOR ORDERS

PART A - Type of Travel

☐ PCS (Reassignment)
☐ PCS (RIF, Base Closure, Unit Deactivation)
☐ PCS (Separation/Retirement)
☐ Other (Specify) _____
☐ Student Education **(See Note 1)**
☐ Renewal Agreement Travel **(See Notes 2-9)**
☐ Advance Return of Family Members **(See Note 11)**
☐ Shipment of HHG and/or POV **(See Notes 9&11)**

PART B - Sponsor's Information

Name: _____ SSN: _____

Current Pay Plan/Series/Grade: _____ Position Title: _____

Current Organization: _____ ZIP Code/APO: _____

Duty /Home Phone: _____ Place of Hire/Home of Record: _____

Alternate Destination(s) **(See Note 4)**: _____

Employee's dates of travel: Depart _____ Return _____

PART C - Family Member(s) Information

Family Member Travel: ☐ Concurrent ☐ Delayed ☐ Early Return

Family Member Travel: from _____ to _____
(City & State of Residence) City &State

Student Travel: ☐ One Way Originating in: ☐ CONUS ☐ Overseas

Student Travel: from _____ to _____

Current enrollment period (dates): from _____ to _____

Family Member Name(s) (Last, First, MI)	**Passport Number**	**Birth Date (See Note 6)**	**Relationship**	**Travel Dates** (Depart/Return) **(See Note 5)**
				-
				-
				-
				-
				-

PART D - PCS Information

Gaining Organization & Address: _____

Reporting date: _____ New Position Title, Series, Grade: _____

PART E - Other Shipment Information

Shipment of Private Owned Vehicle (POV): ☐ Yes **(See Note 9 & 10)** ☐ No

POV Description: _____
(Make, Model, Year, and Serial or Chassis Number of POV)

Shipment of Household Goods (HHG): ☐ Yes ☐ No

Ship HHG from: from _____ to _____
(City & State of Residence)

Shipment of HHG from Nontemporary Temporary Storage (NTS): ☐ Yes ☐ No

Ship NTS from: from _____ to _____

PART F - Mode of Travel

☐ **Government.** I request Government transportation and understand that I must report to TMO to request a Port Call. I also understand that failure to respond to a Port Call will result in forfeiture of Government Travel entitlements for me and my family members

☐ **Privately Owned Vehicle (POV).** I am requesting orders for OCONUS travel and will use my POV for this purpose.

☐ **Commercial.** I request commercial transportation. I understand that reimbursement is limited up to the current official government rate and only when ticket(s) are purchased from the following sources and under conditions stated below:

a. The Contract Ticket Office (CTO)

b. When the services of the CTO are not reasonably available, then ticketing arrangements may be secured from a branch office or general agent of an American flag carrier. Traveler must demonstrate, in writing, to the servicing finance office that the services of the CTO were not reasonably available.

c. When the services of the CTO are not reasonably available and ticketing arrangements cannot be secured from a branch office or general agent of an American flag carrier, the use of travel agents not under contract of the U.S. Government is authorized. Traveler must demonstrate, in writing, to the servicing finance office that the services of the CTO were not reasonably available and the ticketing arrangements could not be secured from a branch office or general agent of an American flag carrier.

PART G - Employee Certification, Supervisor Approval and Fund Certification

1. **Employee Certification:** I certify that the information provided in this request is correct and complete to the best of my knowledge.

_____ _____
(Employee's Signature) (Date)

2. **Supervisor's Approval:**

_____ _____ _____
(Supervisor's Printed or Typed Name) (Supervisor's Signature) (Date Approved)

3. **Fund Certification:** (*Applicable only to current Army Civilians is Europe).* Obtain from your Resource Management Office)**:**

a. Payroll Fund Cite **(Except Student Travel)**: _____

b. Student travel Fund Cite **(Student Travel Only)**: _____

c. PCS/Separation/Retirement/Renewal Agreement Travel/Advance Return of Family Members Fund Cite **(Non-USAREUR Organizations only)**:

_____ _____
(Fund Certifying Official's Signature) (Date)

NOTES TO REQUEST FOR TRAVEL ORDERS

Note 1: Student Travel: You must be eligible for a Living Quarters Allowance (LQA) or Government owned or operated quarters to request student travel orders. Current documentation showing the student is enrolled full-time must be attached to the request for orders. Documentation is required each time student education travel is requested. Secondary school (Grade 9-12) or college (undergraduate) must be located in the US (including Alaska and Hawaii). Student is authorized to ship 350 lbs. net weight of unaccompanied baggage . You must also obtain a student travel fund cite from your Resource Management Office (RMO).

Note 2: Renewal Agreement Travel Noncumulative: RAT entitlement is for use between consecutive periods of continuous overseas employment and may be performed between the date of completion of one agreement and before serving another tour of duty pursuant to a written agreement. Entitlement to renewal agreement travel is not cumulative from one period of service to another if not used. RAT must be performed during your window of eligibility as indicated below:

a. Initial tour (normally 36 mo.): Initial tour has a 18 month window to perform RAT. The window is 6 months prior to initial tour completion and not later than 12 months before completion of tour provided the employee has agreed to a renewal agreement tour (normally 24 mo.). In no instance will RAT be authorized if you have less than 12 months remaining on a tour.

b. Renewal tour (normally 24 mo.): Renewal tour has a 14 month window to perform RAT. The window is 2 months prior to completion of the renewal tour and not later than 12 months before completion of tour provided the employee has agreed to another renewal agreement tour (normally 24 mo.). In no instance will RAT be authorized if you have less than 12 months remaining on a tour.

Note 3: Leave Status during Absences from Duty: You must have approved leave from your supervisor prior to taking RAT. You may be entitled to use home leave, or leave-free travel time (use limited to 1 time per tour), or may be in a leave with or without pay status. A **copy** of your approved leave request SF 71 must be attached to this request if requesting Renewal Agreement Travel.

Note 4: Alternate Point Destination: RAT may be performed to a location in the 50 states and District of Columbia (DC), the Commonwealths of Puerto Rico and the Northern Mariana Island, a U.S. territory or possession, or another country in which the place of actual residence is located is located other than the location of the place of actual residence; however, an employee whose actual residence is in the 50 states and the DC must spend a substantial amount (i.e., majority) of time in the 50 states and DC, the Commonwealths of Puerto Rico and the Northern Mariana Island, a U.S. territory or possession incident to RAT to be entitled to the allowance authorized. The amount allowed for travel and transportation expenses when travel is to an alternate location shall not exceed the amount which would have been allowed for travel over a usually traveled route from the permanent duty station to the place of actual residence and for return to the same or different PDS outside CONUS as the case may be.

Note 5: Travel in Family Unit Not Required: You may travel alone or be accompanied by family members. Family members may travel unaccompanied but cannot perform round trip travel under renewal agreement authority if you do not perform authorized renewal agreement travel. Unaccompanied family members will not be allowed delayed use of renewal agreement authority beyond 6 months after the date you begin such travel.

Note 6: Children Over 21 Years of Age: If a dependent child reaches his/her 21st birthday while you are assigned to a duty station overseas, such former child is entitled to return transportation to your place of actual residence in CONUS provided his/her last travel was at Government expense as the employee family member. Travel **must** be performed when you are performing PCS travel to CONUS, separation travel or renewal agreement travel. Failure to do so will forfeit the right of travel at Government expense of the child. Travel will not be authorized once the child reaches his/her 23 birthday, you may consider returning child under early return of family member if not performing travel before the child reaches 23 years of age.

Note 7: Transportation of Baggage: The maximum baggage allowance that may be authorized at Government expense for you and family members returning to place of actual residence for the purpose of taking RAT will not exceed 350 lbs. for each eligible adult and 175 lbs. for each family member under 12 years of age when travel is performed by ship. When travel is performed over ocean by air the maximum baggage weight allowance that may be authorized at Government expense will not exceed 100 lbs. per person (excluding free checkable baggage) If the baggage moves as accompanied, the authorized amount will be considered as gross weight. If it is shipped as unaccompanied baggage, the authorized amount will be considered as net weight. Shipment of HHG at Government expense as baggage is prohibited in connection with RAT. Baggage allowance will be limited to personal clothing and articles necessary for the trip.

Note 8: Renewal Agreement Travel Limitations:

a. Household Goods (HHG): There is no entitlement to ship HHG in connection with RAT. However, the signing of a renewal agreement in connection with RAT can be the basis for reestablishing expired entitlement for transportation of HHG and family members to extend of prior authorization that was unused.

b. Unaccompanied Family Members: Travel entitlements for unaccompanied family members (see note 3 above).

c. Duplicate eligibility. Duplicate transportation will not be authorized for persons who may be separately eligible of RAT as an employee and as a family member.

Note 9: POV Shipment RAT/Replacement Vehicle: If you plan to ship a POV from CONUS as a replacement vehicle (once every 4 years) attach a copy of your latest POV shipping document (DD Form 788). If reestablishing previously unused shipping entitlements on Renewal Agreement Travel order please provide a signed statement that you never used your POV shipping entitlements on your initial orders and have not shipped a POV overseas at Government expense.

Note 10: POV Shipment (PCS): If you plan to ship a foreign privately owned vehicle (FPOV) at Government expense, the FPOV must meet Department of Transportation (DOT) and US Environmental Protection Agency (EPA) standards (i.e. US Specifications).

Note 11: Return of Family Members and HHG Prior to Return of Employee:

1. Transportation for the return of family members and HHG prior to your return may be authorized in the following circumstances:

a. When you have acquired eligibility for return transportation by satisfactory completing the minimum period of service. No documentation required other than a request for orders;

b. When it is determined by the overseas command concerned the best interests of the Government will be serviced by the return of the family member(s) for compelling personal reason of a humanitarian or compassionate nature such as physical or mental health, death of any member of the immediate family, or obligations imposed by authority or circumstances over which the employee has no control. You must attach a copy of the commander's approval for early return of family member(s) or a command directed early return of family members.

2. If the early return of family members and/or HHG is prior to you attaining eligibility for other than the reason stated in paragraph 1a or b above, then transportation of family members and HHGs will be at the employee's expense. When eligibility is earned for return transportation at Government expense, reimbursement for the proper expense of the transportation, not to exceed the cost for transportation of the family member(s) and HHGs by the most economical route from the overseas post of duty to the place of actual residence. Paid receipt for expenses incurred will be required with the claim along with orders. Orders will not be published until attaining eligibility. If no early return of family member is involved and just shipment of HHG, then reimbursement will not be authorized until such time official orders are issued for employee's PCS or separation travel and will be limited to the cost at the time of actual return travel. Paid receipts will be required for reimbursement.

3. POV shipment is not authorized in conjunction with early return of family member(s) and/or HHG.

CHANGE OF ADDRESS FORM
FOR USAREUR SERVICED ACTIVITIES

The information below is requested to update your personnel and pay records (Leave and Earning Statement (LES) and payroll deducted bonds) with your new mailing address. **Mail or return this form to your servicing Civilian Personnel Advisory Center.**

Name (Print Full Name):

_____ _____ ____
Last First MI

Social Security No. _____-_____-_____

_____ I request that my mailing address for my Leave and Earnings Statement (LES) be changed.

_____ I request that my mailing address for my bond(s) be changed.

I request this change to be effective on _____.

Old Address	**New Address (Must be US Mailing Address)**
1st Line: _____	1st Line: _____
2nd Line: _____	2nd Line: _____
City: _____	City: _____
State: _____ Zip Code: _____	State: _____ Zip Code: _____

_____ _____
SIGNATURE OF EMPLOYEE **DATE**

This form is subject to the Privacy Act of 1974 (5 USC 552a). The information requested will be used to update your records with your U.S. mailing address. Furnishing all requested information will expedite the process of updating your records. The effects of not providing all or part of the requested information may delay your receipt of applicable documents.

ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM EDUCATIONAL SUMMARY

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974
(5 U.S.C. 552A)

AUTHORITY: PL 95-561 *(Defense Dependents' Education Act of 1978)*; PL 101-476 *(Individuals with Disabilities Education Act)*; PL 102-119 *(Individuals with Disabilities Education Act Amendments of 1991)*; DODI 1342.12 *(Provision of Early Intervention and Special Education Services to Eligible DoD Dependents in Overseas Areas)*, March 12, 1996; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DoD Dependents Schools Outside the United States)*, August 28, 1986; 10 USC 3013; 20 USC 921 et seq. and 1400 et seq.

PRINCIPAL PURPOSE: To obtain information needed to evaluate and document the special education and medical needs of:

(1) Family members of all soldiers.

(2) Dependent children of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent travel is authorized at Government expense.

ROUTINE USES: (1) Information will be used by personnel of the military departments to evaluate and document the special education and medical needs of family members. This information will enable --

(a) Military assignment personnel to match the needs of family members against the availability of special education and medical services.

(b) Civilian personnel offices to determine the availability of special education and medically related services to meet the needs of dependent children of Department of the Army civilian employees.

(2) Information will be used by Army Community Service in its Exceptional Family Member Outreach Program.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude --

(1) U.S. Total Army Personnel Command, U.S. Army Reserve Personnel Center, and Army National Guard Readiness Center from enrolling soldiers in the Exceptional Family Member Program *(EFMP)*. Soldiers who knowingly refuse to enroll exceptional family members will receive, at a minimum, a general officer letter of reprimand. A soldier?s refusal to provide information may preclude successful processing of an application for family travel/command sponsorship.

(2) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with dependent children with special needs. Department of the Army civilian employees who refuse to provide information will be denied the privilege of having their dependent children transported to the duty assignment outside the United States at Government expense.

SECTION A - RELEASE OF INFORMATION

1. I release the information on the summary and in the attached reports to personnel of the military departments for the purpose of evaluating and documenting my family member?s need for special education and medical services *(and for military personnel recommendations for my next assignment)*.

2. SIGNATURE OF SPONSOR OR SPONSOR?S SPOUSE	3. DATE SIGNED

SECTION B - SPONSOR INFORMATION *(please print or type)*

4. NAME *(Last, First, Middle Initial)*	5. MILITARY DEPARTMENT AFFILIATION *(Specify if Civilian)*	
6. RANK OR GRADE	7. PRIMARY MOS/BRANCH/CIVILIAN OCCUPATIONAL SERIES	8. SOCIAL SECURITY NUMBER
9. HOME ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		10. HOME PHONE *(Include Area Code)*
11. DUTY ADDRESS *(Must be a 3-line address which includes street address or P.O. Box, and Zip Code)*		12. DUTY PHONE a. DSN b. COMMERCIAL *(Include area code)*
13. PROJECTED LOCATION OF NEXT ASSIGNMENT *(If known)*		14. PROJECTED DATE OF NEXT ASSIGNMENT

SECTION C - FAMILY MEMBER INFORMATION *(please print or type)*			
15. NAME *(Last, First, Middle Initial)*	16. SEX	17. DATE OF BIRTH *(DDMMYYYY)*	18. FAMILY MEMBER PREFIX

SECTION D - EDUCATIONAL SUMMARY

TO BE COMPLETED BY EARLY INTERVENTION PROVIDER/SCHOOL PERSONNEL. This information is used by the Department of Defense in selecting a duty station, including overseas locations, for this child's military sponsor. Please provide complete and accurate information.

19. IS THIS STUDENT ELIGIBLE FOR EARLY INTERVENTION OR SPECIAL EDUCATION AS DESCRIBED IN INDIVIDUALS WITH DISABILITIES EDUCATION ACT? *(X one)*

	a. If "NO," do not complete the remainder of this form. Sign in block at right and return form to sponsor	SIGNATURE	DATE SIGNED
	b. If "YES," complete and sign items 19b thru 30, except for block 29.	SIGNATURE	DATE SIGNED

20. UNDER WHAT CRITERIA IS STUDENT ELIGIBLE FOR SPECIAL EDUCATION? *(May only select 20a, 20b, or 20c)*

a. Ages 3-21 *(X all that apply)*

(X)	CODE		*(X)*	CODE		*(X)*	CODE	
	N07	Autistic		N04	Mentally Retarded		N06	Orthopedically Impaired
	N02	Blind			Mild to moderate		N08	Other Health Impaired
	N11	Visually Impaired			Moderate to severe *(trainable)*		N10	Seriously Emotionally Disturbed
	N01	Deaf			Severe to profound		N12	Specific Learning Disability
	N03	Hearing Impaired		N05	Traumatic brain injury		N09	Speech Impaired

b. Birth through age 2 *(infants and toddlers)*

☐ N13 Developmental Delay ☐ N14 At Risk for Developmental Delay

c. If student is enrolled in the Department of Defense Dependents Schools *(DODDS)*, under which criteria are they qualified for special education?

☐ Criterion A ☐ Criterion B ☐ Criterion C ☐ Criterion D ☐ Criterion E

21. PRESENT LEVEL OF PERFORMANCE *(X appropriate column to indicate student's present level in each area)*

CODE		(1) No Data	(2) Normal	(3) Mild Delay	(4) Moderate Delay	(5) Severe Delay
Q01	a. Self-Help					
Q02	b Gross Motor					
Q03	c. Fine Motor					
Q04	d Social					
Q05	e. Cognitive					
Q06	f. Expressive Language					
Q07	g Receptive Language					

h. Reading and Math Grade Levels *(Use the following codes to indicate reading and math grade levels)*

O - kindergarten 9 - 9th grade A - 10th grade B - 11th grade C - 12th grade W - preschool
Y - no formal education Z - unknown

☐ Reading Grade Level ☐ Math Grade Level

22. SERVICES REQUIRED AND LISTED ON INDIVIDUALIZED EDUCATION PROGRAM *(IEP) (X and complete, as applicable, all services currently received)*

CODE		*(X)*	(1) Duration of Contact *(Minutes)*	(2) Frequency of Contact *(D, W, M, Q, Y)*	(3) Select Highest Level of Intensity		
					Monitoring	Consult	Direct
S01	a. Audiology						
S02	b. Counseling						
S03	c. Occupational Therapy						
S04	d. Psychological Services						
S05	e. Physical Therapy						
S06	f. Therapeutic Recreation						
S07	g. School Health Services						
S08	h. Social Work Services						
S09	i. Speech Therapy						

23. SERVICES REQUIRED AND LISTED ON INDIVIDUALIZED FAMILY SERVICE PLAN *(IFSP) (X and complete as applicable, all services currently received)*

CODE		*(X)*	(1) Duration of Contact *(Minutes)*	(2) Frequency of Contact *(D, W, M, Q, Y)*	(3) Select Highest Level of Intensity		
					Monitoring	Consult	Direct
F10	a. Family Training/Counseling						
F11	b. Special Instruction						
F12	c. Speech Language Pathology						
F03	d. Occupational Therapy						
F05	e. Physical Therapy						
F04	f. Psychological Services						
F13	g. Service Coordination						
F14	h. Diagnostic Medical Services						
F07	i. Health Services						
F15	j. Vision Services						
F08	k. Social Work Services						
F16	l. Assistive Technology						
F17	m. Transportation						

24. Special Transportation ☐ Wheelchair ☐ School Bus Attendant

25. Does student require wheelchair accessibility in school building? ☐ YES ☐ NO

26. Percentage of student's time spent in special education classes or resource room: _____%

27. Does student require residential treatment in order to benefit from educational program? ☐ YES ☐ NO

28. STUDENT'S SPECIAL EDUCATION SERVICE DELIVERY SYSTEM CODE *(Please enter one of the following)*

A - Self-contained residential placement B - Self-contained residential placement in special school
C - Self-contained class in a community public school D - Special education setting for 60 percent or more of the time
E - Pull-out program or resource room program F - Co-teaching or inclusion model
G - Classroom teaching with technical assistance by service provider
H - Progress monitored by service provider

☐

29. OTHER COMMENTS

SECTION E - ACKNOWLEDGEMENTS

30. **SPONSOR OR SPONSOR'S SPOUSE:**

The above information has been reviewed and found to be accurate and complete.

a. SIGNATURE	b. DATE SIGNED

31. **SCHOOL PERSONNEL**

a. TYPED OR PRINTED NAME *(Last, First, MI)*	b. TITLE	c. TELEPHONE *(Include area code)*
d. NAME OF SCHOOL	e. ADDRESS *(Include Zip Code)*	f. SCHOOL DISTRICT
g. SIGNATURE		h. DATE SIGNED

31. FOR USE BY MEDICAL COMMAND AND ASSIGNMENT PERSONNEL ONLY

32. FOR USE IN THE EFMP CODING PROCESS:

a. Special medical needs that need to be coordinated with overseas command ☐ YES ☐ NO

b. Disenrollment code *(If applicable, please enter one of the following)*

D - Death E - Educational Condition No Longer Exists M - Medical Condition No Longer Exists
N - No Longer Meets Requirements S - Separation/Retirement V - Divorce

c. NAME OF CODER *(Last, First, Middle Initial)*	d. MEDICAL TREATMENT FACILITY CODE

ROTATION AGREEMENT - EMPLOYEES RECRUITED FROM THE UNITED STATES

For use of this form, see AR 690-300, chapter 301; the proponent agency is DCSPER

This agreement must be signed by an employee recruited from the United States *(US)* for an assignment with career or career-conditional status to a Department of the Army *(DA)* position in any foreign area and the Republic of Panama. It covers employees recruited from within DA, from other Federal agencies, and from outside the Federal service. This agreement must be signed before an employee may be assigned to a position in a foreign area.

This document is an agreement between the DA and the employee named in item 1 below regarding the requirements of the DA Rotation Program. This agreement becomes effective upon the employee's initial assignment to the foreign area listed in item 2 below; it remains in effect throughout all approved extensions.

The initial period of the employee's overseas tour is shown in item 4 below. Extensions beyond the initial tour are authorized if management decides that an extension is in the best interest of DA and the employee consents to the extension. Such an extension is initiated only by management. A management decision to return the employee to the US rather than to grant an extension is not grievable by the employee. (See AR 690-700, chap 771, para 1-7b(15)).

The employee recognizes the obligation to apply for assignment to the US before completion of the overseas tour or extension(s) thereof as specified in DOD 1400.20-1-M (DOD Program for Stability of Civilian Employment Policies, Procedures, and Programs Manual). This application must be made within 7 workdays following the date of a management decision not to extend the employee's tour. DA agrees to give the employee timely notice of the requirement to apply for assignment. If notice to the employee is delayed, the employee's application may be delayed until not later than 30 calendar days after the date of the notice.

Reemployment rights (if applicable) are to the position shown in item 3 below. If the employee has reemployment rights to a position in the US at a grade equal to or higher than the one occupied 6 months before completion of the overseas tour, the employee will apply to exercise these rights. If reemployment rights are to a lower grade, the employee may either exercise these rights or register in the DOD Priority Placement Program (PPP).

When the employee does not have reemployment rights, or when these rights will not be exercised, application for return to the US will be made through the PPP. The employee agrees to expand availability to the geographic area considered necessary by the registering Civilian Personnel Office to assure receipt of one valid offer of continued employment from the US. The employee's initial availability will be for up to one full PPP Zone; this Zone will be the Zone in the US from which the employee was recruited or a Zone less distant from the overseas activity. If an offer is not received within the first 90 calendar days, the employee's availability will be expanded to at least two full PPP Zones. If an offer is not received within the succeeding 90 calendar days, the employee's availability will be expanded nationwide. The employee agrees to accept, as outlined in DOD 1400.20-1-M, the first valid offer of continuing employment made from the US. The employee will then return to the US within 30 calendar days. With the concurrence of the gaining activity in the US, this time period normally may be extended not to exceed 45 calendar days.

DA agrees to reasonably help the employee to apply for return placement in the US. Also, DA agrees to help the employee to obtain a valid offer of continuing employment which is consistent with the employee's geographic and occupational availability.

By signing at item 5 below or in the appropriate signature block item on the extension addendum, the employee agrees to the above conditions of employment and understands that failure to abide by the terms of the agreement may result in a proposal to separate the employee from the Federal service.

This agreement becomes void if, before completion of the overseas tour, the employee transfers to a Federal agency outside the Department of Defense or is voluntarily or involuntarily separated.

ROTATION AGREEMENT - EMPLOYEES RECRUITED FROM THE UNITED STATES *(Cont'd)*

1. NAME OF EMPLOYEE

2. POSITION AND AREA FOR WHICH SELECTED

3. REEMPLOYMENT RIGHTS

___ NONE

TO _____

4. INITIAL OVERSEAS TOUR _____ MONTHS DATE TOUR BEGINS _____

5. EMPLOYEE'S SIGNATURE

6. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

7. DATE OF AGREEMENT

1ST EXTENSION*

8. DATE OF APPROVED EXTENSION _____ FOR _____ MONTHS

9. EMPLOYEE'S SIGNATURE

10. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

11. DATE OF AGREEMENT

2ND EXTENSION*

12. DATE OF APPROVED EXTENSION _____ FOR _____ MONTHS

13. EMPLOYEE'S SIGNATURE

14. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

15. DATE OF AGREEMENT

3RD EXTENSION*

16. DATE OF APPROVED EXTENSION _____ FOR _____ MONTHS

17. EMPLOYEE'S SIGNATURE

18. TITLE AND SIGNATURE OF PERSONNEL REPRESENTATIVE

19. DATE OF AGREEMENT

*If reemployment rights are extended, attach a completed Supplement to Reemployment Rights Agreement. *(See AR 690-300, chap 352, app C.)*

EXCEPTIONAL FAMILY MEMBER PROGRAM INFORMATION SHEET

For use of this form, see AR 608-75; the proponent agency is OACSIM

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: PL 94-142 *(Education for All Handicapped Children Act of 1975);* PL 95-561 *(Defense Dependents' Education Act of 1978);* DODI 1342-12 *(Education of Handicapped Children in DODDS),* 17 December 1981; DODI 1010.13 *(Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DOD Dependents Schools Outside the United States),* 28 August 1986, 10 USC 3013; 20 USC 921-932 and 1401 et. seq.

PRINCIPAL PURPOSE: To identify the special education and medical needs of dependent children and medical needs of adult family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent family member travel is authorized at Government expense.

ROUTINE USES: Information will be used by civilian personnel offices to determine the need for coordinating the availability of medically related services to meet the special needs of dependent children and medical needs of family members of Department of the Army civilian employees processing for an assignment to a location outside the United States where dependent family member travel is authorized at Government expense.

DISCLOSURE: The provision of requested information is mandatory. Failure to respond will preclude--
(1) Civilian personnel offices from performing required EFMP aspects of overseas processing of Department of the Army civilian employees with family members with special needs.

(2) Transportation of family members of Department of the Army civilian employees to duty assignments outside the United States at Government expense.

CONFIDENTIALITY: Information obtained will be maintained in strict confidence and provided only to those with an official need to know in identifying special needs and in processing personnel for assignments outside the United States.

PART A - GENERAL INFORMATION

ALL EMPLOYEES TAKING AN ASSIGNMENT IN A LOCATION OUTSIDE THE UNITED STATES WHERE FAMILY MEMBER TRAVEL IS AUTHORIZED AT GOVERNMENT EXPENSE MUST COMPLETE THIS FORM. EMPLOYEES WHO DO NOT HAVE FAMILY MEMBERS MUST COMPLETE BLOCKS 1-7 AND SIGN THE APPROPRIATE CERTIFICATION STATEMENT BELOW.

1. SPONSOR'S NAME *(Last, first, MI)*	2. SPONSOR'S SOCIAL SECURITY NUMBER
3. SPONSOR'S TITLE	4. SPONSOR'S GRADE
5.a. SPONSOR'S HOME ADDRESS	6. SPONSOR'S HOME PHONE *(Include area code)*
5.b. SPONSOR'S DUTY ADDRESS	7. SPONSOR'S DUTY PHONE a. DSN b. COMMERCIAL *(Include area code)*

PART B - FAMILY MEMBERS AUTHORIZED TRAVEL OUTSIDE THE UNITED STATES

8. NAME *(Last, first, MI)*	9. RELATIONSHIP	10. DOB *(YYYYMMDD)*	11. SEX
a.			
b.			
c.			
d.			
e.			

12. PLEASE READ ALL OF THE FOLLOWING QUESTIONS VERY CAREFULLY AND SIGN THE APPROPRIATE CERTIFICATION STATEMENT IN k. BELOW.

a. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A LONG TERM *(i.e., more than one year's duration)* PHYSICAL OR EMOTIONAL ILLNESS?

b. ARE ANY OF THE ABOVE FAMILY MEMBERS BEING SEEN AT A HOSPITAL OR CLINIC REGULARLY? *("Regularly" means about every 2 months or more often and 4 or 5 times a year or more often.)*

c. WILL ANY OF THE ABOVE FAMILY MEMBERS NEED TO BE SEEN AT A HOSPITAL OR CLINIC OUTSIDE THE UNITED STATES REGULARLY BASED ON THEIR PRESENT MEDICAL CONDITION?

d. HAVE ANY OF THE ABOVE FAMILY MEMBERS BEEN TOLD THEY SHOULD BE SEEN REGULARLY AT A HOSPITAL OR CLINIC BUT ARE NOT BEING SEEN?

e. ARE ANY OF THE ABOVE FAMILY MEMBERS ENROLLED IN A SPECIAL EDUCATION PROGRAM?

f. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A LEARNING DISABILITY?

g. ARE ANY OF THE ABOVE FAMILY MEMBERS BLIND, DEAF, OR HARD OF HEARING?

h. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A SPEECH PROBLEM THAT REQUIRES THE SERVICES OF A SPEECH THERAPIST?

i. DO ANY OF THE ABOVE FAMILY MEMBERS HAVE A PHYSICAL DISABILITY THAT COULD AFFECT THEIR LEARNING?

j. DO ANY OF THE ABOVE FAMILY MEMBERS REQUIRE PROFESSIONAL COUNSELING REGARDING PROBLEM BEHAVIOR, SUCH AS ABUSE OF ALCOHOL OR DRUGS, RUNNING AWAY, SKIPPING SCHOOL, OR OTHER DELINQUENT-TYPE ACTS?

k. **SIGN ONE OF THE CERTIFICATIONS BELOW**

(1) I CERTIFY THAT I DO NOT HAVE FAMILY MEMBERS.

(a) SIGNATURE OF SPONSOR	(b) DATE *(YYYYMMDD)*

(2) I CERTIFY THAT MY ANSWER TO EACH OF THE ABOVE QUESTIONS IS NO FOR EACH OF THE FAMILY MEMBERS LISTED ABOVE.

(a) SIGNATURE OF SPONSOR	(b) DATE *(YYYYMMDD)*

(3) I CERTIFY THAT ONE OR MORE OF MY ANSWERS TO THE ABOVE QUESTIONS IS YES REGARDING A FAMILY MEMBER LISTED ABOVE. *(Check appropriate block below)*

☐ I INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL WITH ME CONCURRENTLY.

☐ I INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL ON A DELAYED BASIS.

☐ I DO NOT INTEND THAT THE FAMILY MEMBER OR FAMILY MEMBERS WILL TRAVEL TO MY NEW DUTY LOCATION OUTSIDE THE UNITED STATES. I UNDERSTAND THAT A DA FORM 5862-R *(ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM MEDICAL SUMMARY)* AND DA FORM 5291-R *(ARMY EXCEPTIONAL FAMILY MEMBER PROGRAM EDUCATIONAL SUMMARY) (WHEN APPLICABLE)* MUST BE COMPLETED ON THE FAMILY MEMBER OR FAMILY MEMBERS AND PROVIDED TO THE CIVILIAN PERSONNEL OFFICE SHOULD I, AT A LATER DATE, DECIDE TO HAVE THE FAMILY MEMBER OR FAMILY MEMBERS JOIN ME AND THIS MUST BE ACCOMPLISHED PRIOR TO THEIR ARRIVAL AT THE LOCATION OUTSIDE THE UNITED STATES.

(a) SIGNATURE OF SPONSOR	(b) DATE *(YYYYMMDD)*

DEPARTMENT OF DEFENSE (DOD) TRANSPORTATION AGREEMENT
TRANSFER OF CIVILIAN EMPLOYEES OUTSIDE CONUS (OCONUS)

(Outside the 48 Contiguous States and the District of Columbia)

PRIVACY ACT STATEMENT

(5 U.S.C. §552a)

AUTHORITY: 5 U.S.C. §5701, §5722, §5723, §5724, and E.O. 9397 (SSN).

PRINCIPAL PURPOSE(S): Used to establish Government time in service requirements in order for the employee (including appointees and student trainees) to be eligible for travel and transportation expenses when transferred to positions outside the Continental United States (OCONUS).

ROUTINE USE(S): In addition to being used by officials and employees of the applicant's Service in determining eligibility for travel and transportation expenses, the information contained herein may be provided to law enforcement personnel investigating those suspected of fraudulently obtaining allowances.

DISCLOSURE: Voluntary; however, completion of this form is necessary before transfer can be authorized and expenses paid. The personal information requested is necessary to properly identify the employee.

A. EMPLOYEE NAME *(Last, First, Middle Initial)*	**B. TYPE OF AGREEMENT**	
	☐ **INITIAL**	☐ **PERMANENT CHANGE OF STATION (PCS) ONLY**
	☐ **RENEWAL**	☐ **RENEWAL IN CONJUNCTION WITH PCS**

C. EMPLOYEE SSN	**D. NEW APPOINTEE OR STUDENT TRAINEE**	**E. REPORT DATE TO NEW OR FIRST PERMANENT DUTY STATION (PDS)** *(YYYYMMDD)*
	☐ **YES** ☐ **NO**	

F. LAST PDS LOCATION	**G. ACTUAL RESIDENCE AT TIME OF APPOINTMENT** *(To be determined at time of initial agreement)*

1. 5 U.S.C. §5722 and §5723, provide, under certain conditions, for travel and transportation expenses of the employee (including new appointees or student trainees eligible for first PDS travel), appropriate allowances for the employee's immediate family, movement and storage of household goods (HHG) and personal effects, and certain other allowances incident to an appointment or transfer to an OCONUS location, except movement and storage of HHG is not allowed for round-trip renewal agreement travel. Under the law, the allowances shall not be authorized unless the employee agrees in writing to remain in the Government service for a prescribed period of time. Accordingly, to establish eligibility for the authorized allowances, the following agreement must be executed.

2. I understand and agree that:

a. When I complete _____ months, the prescribed tour of duty, I will be eligible for return travel and transportation allowances at Government expense for myself, my dependents, or my household effects, to my actual residence at time of appointment stated above for purpose of separation from the service, unless separated early for reasons beyond my control that are acceptable to the agency concerned.

b. I will remain in Government service for at least 12 months beginning with the effective date of my transfer or appointment to my new OCONUS PDS, unless separated for reasons beyond my control that are acceptable to the agency concerned. If I fail to remain in service the required minimum period of time, or if I am removed for cause before expiration of the required minimum period of service, I am obligated and will, upon demand, repay to the Government a sum of money equivalent to what the Government paid for travel and transportation and related allowances associated with the transfer of myself and my dependents, e.g., HHG storage and shipment, CONUS temporary quarters subsistence expenses, (but not OCONUS temporary quarters subsistence allowance), real estate and/or relocation expenses, miscellaneous expenses, and any other related allowances incident to my transfer, from beginning point of travel to the PDS. The employing Agency may withhold any final pay due to me to apply against or liquidate any indebtedness arising from a violation of this agreement.

3. I understand that the period of service specified above is for the sole purpose of establishing my eligibility for travel and transportation allowances, and other related allowances which may be authorized.

(Continued on Back)

H. EMPLOYEE SIGNATURE	**I. DATE SIGNED** *(YYYYMMDD)*

4. I understand and agree that the address shown above is my actual residence at time of appointment and that it will be used for the purpose of determining transportation entitlement and that this address is not subject to later change for personal reasons.

5. I understand that I may be required to use commercial or Government aircraft for necessary travel to or from my OCONUS PDS unless a medical reason precludes the use of aircraft.

6. I also understand it is neither cost effective nor efficient for DoD to provide more than one PCS move at Government expense during any 12-month period. Accordingly, except as provided in JTR, par. C4100, I am not entitled to any further PCS transfers within DoD, at Government expense, for a period of 12 months from the date of this transfer. This policy does not preclude my acceptance of another position for which PCS expenses may not be allowed.

NOTE: Employee should retain a copy of signed transportation agreement for their personal files.

J. OTHER REMARKS *(To be completed by personnel office or employing agency officials only.)*

RECORD OF EMERGENCY DATA

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 1475 to 1480 and 2771, 38 USC 1970, 44 USC 3101, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSES: This form is used to designate beneficiaries for certain benefits in the event of the servicemember's death. It is a guide for the disposition of that member's pay and allowances if captured, missing or interned. It also shows names and addresses of the person(s) the servicemember desires to be notified in case of emergency or death. The purpose of soliciting the SSN is to provide positive identification.

ROUTINE USES: None.

DISCLOSURE: Voluntary; however, failure to provide personal identifier information may delay notification of the servicemember's status or may handicap processing of benefits to designated beneficiaries.

INSTRUCTIONS TO SERVICEMEMBER

This extremely important form is to be used by you to show the names and addresses of your spouse, children, parents, and any other person(s) you would like notified if you become a casualty, and, to designate beneficiaries for certain benefits if you die. IT IS YOUR RESPONSIBILITY to keep your Record of Emergency Data up to date to show your desires as to bene- ficiaries to receive certain death payments, and to show changes in your family or other dependents listed; for example, as a result of marriage, civil court action, death, or address change. Regarding your designation in Item 11, "Allotment if Missing" (if used by your Service), please read the following statement carefully, and sign on the line provided:

I fully understand that, if I am captured, missing, or interned, my designation of allotments to dependents from my pay and allowances serves only as a guide to the Secretary of my Service. The Secretary may alter my designated allotment in the best interests of myself, my dependents, or the United States Government.

_____

(Signature of Servicemember)

1. NAME *(Last, First, Middle)*	**2a. SSN**	**b. INITIAL** *(To indicate valid SSN)*	**3a. SERVICE**	**b. REPORTING UNIT CODE DUTY STATION**

4a. SPOUSE NAME	**b. ADDRESS** *(Include ZIP Code)*

5. CHILDREN **a. NAME**	**b. RELATIONSHIP**	**c. DATE OF BIRTH** *(YYYYMMDD)*	**d. ADDRESS** *(Include ZIP Code)*

6a. FATHER NAME	**b. ADDRESS** *(Include ZIP Code)*

7a. MOTHER NAME	**b. ADDRESS** *(Include ZIP Code)*

8a. DO NOT NOTIFY DUE TO ILL HEALTH	**b. NOTIFY INSTEAD**

9a. BENEFICIARY(IES) FOR DG *(If no surviving spouse or child)*	**b. ADDRESS** *(Include ZIP Code)*	**c. PERCENTAGE**

10a. BENEFICIARY(IES) FOR UNPAID PAY/ ALLOWANCES	**b. ADDRESS** *(Include ZIP Code)*	**c. PERCENTAGE**

11. ALLOTMENT DESIGNEE/PERCENTAGE IF MISSING *(Subject to Secretarial determination)*

12. INSURANCE *(SGLI and other Insurance Companies/Policy Numbers)*	**a. SGLI** *(Optional Service Use)* ☐ **MAXIMUM** ☐ **NO** ☐ **OTHER** *(Amount)* _____	**b. INSURANCE COMPANIES/POLICY NUMBERS**

13. CONTINUATION/REMARKS

14. SIGNATURE OF SERVICEMEMBER *(Include rank, rate, or grade)*	**15. SIGNATURE OF WITNESS** *(Include rank, rate, or grade)*	**16. DATE SIGNED** *(YYYYMMDD)*

INSTRUCTIONS FOR PREPARING DD FORM 93

(See appropriate Service Directives for supplemental instructions for completion of this form at other than MEPS)

All entries explained below are for electronic or typewriter completion, except those specifically noted. If computer or typewriter is not available, print in black or blue-black ink insuring a legible image on all copies. Include "Jr.," "Sr.," "III" or similar designation for each name, if applicable. When an address is entered, include the appropriate ZIP code. If the member cannot provide a current address, indicate "unknown" in the appropriate item. Addresses shown as P.O. Box Numbers or RFD numbers should indicate in Item 13, "Continuations", a street address or general guidance to reach the place of residence. In addition, the notation "See Item 13" should be included in the item pertaining to the particular next of kin. If the address for the person in the item has been shown in a preceding item, it is unnecessary to repeat the address; however, the name must be entered. When the space for a particular item is insufficient, insert "See #13" and continue the information in Item 13. Also see preparation instructions for Item 13.

ITEM 1. Member's full last name, first name, middle name.

ITEM 2a. Member's social security number (SSN).

ITEM 2b. Member's initials in ink, verifying SSN accuracy.

ITEM 3a. Service. Use standard one-letter Service code (A - Army, F - Air Force, N - Navy, M - Marine Corps).

ITEM 3b. Reporting Unit Code/Duty Station. Army/Air Force/Navy - see Service Directives. Marine Corps - MEPS enters Monitored Command Code (MCC) to which the member will be assigned.

ITEM 4. First name, middle initial, maiden name (if applicable), and address of spouse. If member is single, divorced, or widowed, so state.

ITEM 5. First name, middle initial, last name (only if different from member's), relationship to member, and date of birth of all children. If none, so state. Include illegitimate children if acknowledged by member or paternity/maternity has been judicially decreed. Indicate relationship, for example: 03 - son, 04 - daughter, 13 - stepson,
14 - stepdaughter, 33 - adopted daughter, 34 - adopted son. Sample entries: Mary A./04/19650704; Donald E. Jones/13/19630102. For children not living with the member's current spouse, include address and name and relationship of person with whom residing.

ITEM 6. First name, middle initial, last name, and address of father. If unknown or deceased, so state. Include civilian title or military grade if applicable. If other than natural father is listed, indicate relationship.

ITEM 7. First name, middle initial, last name, and address of mother. If unknown or deceased, so state. Include civilian title or military grade if applicable. If other than natural mother is listed, indicate relationship.

ITEM 8. Persons not to be notified due to ill health.
a. List relationship, e.g., "Mother," of person(s) listed in Items 4, 5, 6, or 7 who are not to be notified of a casualty due to ill health. If more than one child, specify, e.g., "daughter Susan."
b. List relationship, e.g., "Father" or name and address of person(s) to be notified in lieu of person(s) listed in item 8a.

ITEM 9. First name, last name, address, and relationship of person(s) to receive the 6 months' gratuity pay if there is no surviving spouse or child at the time of death. Only parents (including a person in loco parentis status) and brothers and sisters (including those of half-blood and those through adoption) may be designated. Loco Parentis means any person(s) who acted in place of the member's parent(s) for a period of not less than one year at any time before the member entered on active duty. If brothers or sisters are designated, show date of birth (YYYYMMDD). Show percentage to be paid to each person if two or more beneficiaries are designated. The sum shares must equal 100 percent. If no percentage is indicated and more than one person is named, the money is paid in equal shares to the persons named. Enter "None" if the member has no eligible beneficiary. No benefit can be paid in that instance (10 USC 1477). Also enter "None" if the member does not wish to designate a beneficiary. Payment then is made in the order of precedence established by law. The member should make specific designation, however, as it expedites payment.

ITEM 10. First name, middle initial, last name, address and relationship of person(s) to receive unpaid pay and allowances at time of death. The member may indicate anyone to receive this payment. If member designated two or more beneficiaries, state the percentage to be paid for each. The sum shares must equal 100 percent. If the member does not wish to designate a beneficiary, enter "None." The member is urged to designate a beneficiary for unpaid pay and allowances as payment will be made to the person in the order of precedence established by law (10 USC 2771) in the absence of a designation.

ITEM 11. First name, middle initial, last name, relationship, and address of dependent(s) the member designates to receive an allotment of pay if missing, captured, or interned. This allotment may be initiated by the Service Secretary or his designee in the event the member enters a missing status. This item may be left blank. If member designates two or more allottees, state the percentage to be paid to each. The sum shares need not equal 100 percent, but may not exceed 100 percent. NOTE: Designations made in Item 11 are used as a guide by the Service Secretary or designee in establishing, changing, or discontinuing an allotment in the interest of the member (37 USC 551-558). The final decision rests with the Service Secretary or designee.

ITEM 12. Insurance information.
a. Serviceman's Group Life Insurance (SGLI). Not applicable for Marine Corps and Air Force members. NOTE: Completion of this item does not constitute a SGLI election or designation or beneficiary(ies). Indicate, by entering an "X" in the appropriate block, the member's SGLI election (as stated in VA Form 29-8286). For Navy members, on the next line, enter, as appropriate, either: "Bene Desig filed (YYYYMMDD)," or "Bene Desig not filed."
b. Insurance companies/policy numbers. Enter full name of all commercial life insurance companies to be notified in case of death. Enter policy number if member desires; this expedites settlement of claims.

ITEM 13. Continuations/remarks. Use this item for remarks or continuation of other items, if necessary. Prefix entry with the number of the item being continued; for example, 5/John J./03/19451220/321 Pecan Drive, Schertz TX 78151. Also use this item to list name, address, and relationship of other persons the member desires to be notified. Other dependents may also be listed.

ITEM 14. Member's signature. Have the member check and verify all entries and sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade.

ITEM 15. Signature of witness. Have a witness (disinterested person) sign all copies in ink as follows: First name, middle initial, last name. Include rank, rate, or grade.

ITEM 16. Date the member signs the form. This item is an ink entry and must be completed by the member on four copies.

EMPLOYEE'S EDUCATIONAL INFORMATION

Circle highest educational level attained (DIN ECB) (Table 469)		**Insert instructional program studied (DIN ECC) (Table 468)**	**Insert total college credit hours earned (DIN ECE)**	**Circle type of college credit hours earned (DIN ECF) (Table 157)**	**Circle type of school attended at highest educational level attained (DIN ECG) (Table 137)**	**Circle whether a major or minor academic discipline was achieved in the instructional program studied (DIN ECH) (Table 161).**	**Insert the name and state of the academic institution attended at highest educational level attained (DIN ECJ) (Table 332)**	**Enter the year the highest education level was attained. If bachelors or higher, enter the year of the highest degree. (DIN ECI)**
01 No formal education or some elementary school-did not complete 02 Elementary school completed-no high school 03 Some high school - did not graduate 04 High school graduate or certificate of equivalency 05 Terminal occupational program-did not complete 06 Terminal occ prgm-certificate of completion, diploma or equivalent 07 Some college-less than one year	08 1 year college 09 2 years college 10 Associate degree 11 3 years college 12 4 years college 13 Bachelor's degree 14 Post bachelor's 15 First professional degree 16 Post-first professional 17 Master's degree 18 Post master's 19 Sixth-year degree 20 Post-sixth year 21 Doctorate degree 22 post-doctorate	_____ _____ _____ _____ _____ _____ _____ Examples: mechanical engineer; optical; nursing, surgical; nursing, anesthetist; veterinary surgery; sport and fitness administration/management; business administration and management, general; purchasing, procurement and contracts management)	_____ _____ _____ _____ _____ _____ _____	not applicable 1 semester hours 2 quarter hours 3 other (classroom)	not applicable b junior college c college or university h high school s secretarial, business or commercial school v vocational, trade or technical school (at high school level) w vocational, trade or technical school (above high school level)	not applicable 0 none 1 major field of study (20 semester or 30 quarter units) 2 minor field of study (12 semester or 18 quarter units) 9 unknown		_____

I hereby certify that to the best of my knowledge above information concerning my educational background is complete and correct.

NAME: _____ SSN: _____ SIGNATURE: _____ DATE: _____

NOTICE OF NON-TEMPORARY STORAGE

NAME:_____ SSN: _____

ORGANIZATION ADDRESS:
_____

MAILING
ADDRESS:_____

TRANSPORTATION OFFICE THAT PROCESSED NTS SHIPMENT:
_____

ENTRANCE ON DUTY: _____ DUTY PHONE: _____

PRIVACY ACT AND PUBLIC BURDEN STATEMENT

The Office of Personnel Management is authorized to request this information under sections 1302, 3301, 3304, and 8716 of title 5 of the U.S. Code. Section 1104 of title 5 allows the Office of Personnel Management to delegate personnel management functions to other Federal agencies. If neces- sary, and usually in conjunction with another form or forms, this form may be used in conducting an investigation to determine your suitability or your ability to hold a security clearance, and it may be disclosed to authorized officials making similar, subsequent determinations.

Public burden reporting for this collection of information is estimated to vary from 5 to 30 minutes with an average of 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of the collection of information, including suggestions for reducing this burden, to Reports and Forms Management Officer, U.S. Office of Personnel Management, 1900 E Street, N.W., Washington, D.C. 20415.

ROUTINE USES: Any disclosure of this record or information in this record is in accordance with routine uses found in System Notice OPM/GOVT-1, General Personnel Records. This system allows disclosure of information to training facilities; organizations deciding claims for retirement, insurance, unemployment, or health benefits; officials in litigation or administrative proceeding where the Government is a party; law enforcement agencies concerning a violation of law or regulation; Federal agencies for statistical reports and studies; officials of labor organizations recognized by law in connection with representing employees; Federal agencies or other sources requesting information for Federal agencies in connection with hiring or retaining, security clearance, security or suitability investigations, classifying jobs, contracting, or issuing licenses, grants, or other benefits; public and private organizations, including news media, which grant or publicize employee recognition and awards; the Merit Systems Protection Board, the Office of Special Counsel, the Equal Employment Opportunity Commission, the Federal Labor Relations Authority, the National Archives, the Federal Acquisitions Institute, and Congressional offices in connection with their official functions; prospective non-Federal employers concerning tenure of employ- ment, civil service status, length of service, and the date and nature of action for separation as shown on the SF 50 (or authorized exception) of a specifically identified individual; requesting organizations or individuals concerning the home address and other relevant information on those who might have contracted an illness or been exposed to a health hazard; authorized Federal and non-Federal agencies for use in computer matching; spouses or dependent children asking whether the employee has changed from a self-and-family to a self-only health benefits enrollment; individuals working on a contract, service, grant, cooperative agreement, or job for the Federal government; non-agency members of an agency's performance or other panel; and agency- appointed representatives of employees con- cerning information issued to the employee about fitness-for-duty or agency-filed disability retirement procedures.

Optional Form 306 (EG)
September 1994
U.S. Office of Personnel Management

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

GENERAL INFORMATION

1 FULL NAME ►

2 SOCIAL SECURITY NUMBER ►

3 PLACE OF BIRTH *(Include City and State or Country)* ►

4 DATE OF BIRTH *(MM/DD/YY)* ►

5 OTHER NAMES EVER USED *(For example, maiden name, nickname, etc.)* ►

►

6 PHONE NUMBERS *(Include Area Codes)*

DAY ►

NIGHT ►

MILITARY SERVICE

	Yes	No
7 Have you served in the United States Military Service? *If your only active duty was training in the Reserves or National Guard, answer "NO".*		

If you answered "YES", list the branch, dates (MM/DD/YY), and type of discharge for all active duty military service.

BRANCH	FROM	TO	TYPE OF DISCHARGE

BACKGROUND INFORMATION

For all questions, provide all additional requested information under item 15 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 8, 9, and 10, your answers should include convictions resulting from a plea of nolo contendere *(no contest)*, but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar State law, and (5) any conviction whose record was expunged under Federal or State law.

	Yes	No
8 During the last 10 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.*		
9 Have you been convicted by a military court-martial in the past 10 years? (If no military service, answer "NO".) *If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.*		
10 Are you now under charges for any violation of law? *If "Yes", use item 15 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* . .		
11 During the last 5 years, were you fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management? *If "Yes", use item 15 to provide the date, an explanation of the problem and reason for leaving, and the employer's name and address.*		
12 Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "Yes", use item 15 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* .		

ADDITIONAL QUESTIONS

	Yes	No
13 Do any of your relatives work for the agency or organization to which you are submitting this form? (Includes father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, step-son, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "Yes", use item 15 to provide the name, relationship, and the Department, Agency, or Branch of the Armed Forces for which your relative works.*		
14 Do you receive, or have you ever applied for, retirement pay, pension, or other pay based on military, Federal civilian, or District of Columbia Government service?		

CONTINUATION SPACE/AGENCY OPTIONAL QUESTIONS

15 Provide details requested in items 8 through 13 and 17c in the continuation space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed (these questions are specific to your position, and your agency is authorized to ask them).

CERTIFICATIONS/ADDITIONAL QUESTION

APPLICANT: If you are applying for a position and have not yet been selected. Carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, complete item 16/16a.

APPOINTEE: If you are being appointed. Carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, complete item 16/16b and answer item 17.

16 **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. **I understand** that a false or fraudulent answer to any question on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. **I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by *employers, schools, law enforcement agencies,* and *other individuals and organizations* to *investigators, personnel specialists, and other authorized employees of the Federal Government.* **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

16a **Applicant's Signature** ▶ *(Sign in ink)* **Date** ▶

16b **Appointee's Signature** ▶ *(Sign in ink)* **Date** ▶

APPOINTING OFFICER: Enter Date of Appointment or Conversion ▶

17 **Appointee Only *(Respond only if you have been employed by the Federal Government before):*** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

	Date *(MM/DD/YY)*		
	Yes	No	Don't Know
17b When you worked for the Federal Government last time, did you waive Basic Life Insurance or any type of optional life insurance?			
17c If you answered "Yes" to item 17b, did you later cancel the waiver(s)? *If your answer to item17c is "No," use item 15 to identify the type(s) of insurance for which waivers were not cancelled.*			

17a When did you leave your last Federal job? . . . . . .

Optional Form 306
U.S. Office of Personnel Management

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

INSTRUCTIONS

The information collected on this form is used to determine your acceptability for Federal employment and your enrollment status in the Government's Life Insurance program. You may be asked to complete this form at any time during the hiring process. Follow instructions that the agency provides. If you are selected, you will be asked to update your responses on this form and on other materials submitted during the application process and then to recertify that your answers are true before you are appointed.

Your Social Security Number is needed to keep our records accurate, because people may have the same name and birthdate. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records. Giving us your SSN or other information is voluntary. However, if you do not give us your SSN or any other information requested, we cannot process your application. Incomplete addresses and ZIP Codes may also slow processing.

You must answer all questions truthfully and completely. A false statement on any part of this declaration or attached forms or sheets may be grounds for not hiring you, or for firing you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, title 18, section 1001.)

Either type your responses to this form or print clearly in dark ink. If you need additional space, attach letter-size sheets (8.5" X 11"), including your name, Social Security Number, and item number on each sheet. It is recommended that you keep a photocopy of your completed form for your records.

Subject: Request for Identification (ID) Card(s)

Request preparation of DD Form 1172 (Application for Uniformed Services Identification Card DEERS Enrollment) for the following individual(s). The reason(s) for needing ID cards is provided below. I also understand that I must provide the required documentation listed below when I pick up the completed DD Form 1172 from the CPAC, even if I provided documentation in the past.

Reason: _____ _____

Initial, Renewal, Lost or Destroyed (provide date, time & location), Other (specify)

Individual Information	**Sponsor**	**Spouse/First Family Member**
Name (Last, First, MI.):		
Sex (Female-F/Male-M):		
Relationship (2 character code):	**(family members only)**	
Social Security Number:		
Status (CIV or RET Civ & Mil):		
Civ Pay Plan/Grade (e.g.WG5/GS11):		
Ret Mil Br Of Svc (USA/USAF/Navy):		
Ret Mil Pay Grade (E8/W3/04):		
Ret Mil Rank (MSG/CW0-3/LCDR):		
Unit (Include CMR/Unit # & APO #):		
Duty Telephone Number (DSN):		
DOB (yyyymmmdd/e.g.: 1951Aug09):		
Color Of Eyes (2 character code):		
Color Of Hair (2 character code):		
Height (Inches/2 characters 5'-6" = 66):		
Weight (Lbs./3 characters 90 lbs = 090):		
Marital Status (3 character code):		
DEROS (yyyymmmdd/e.g.: 2004Jun07):		
Date Of Marriage (yyyymmmdd):	**(spouse only)**	

Individual Information	**Second Family Member**	**Third Family Member**
Name (Last, First, MI.):		
Sex (Female-F/Male-M):		
Relationship (2 character code):		
Social Security Number:		
DOB (yyyymmmdd/e.g.: 1951Aug09):		
Color Of Eyes (2 character code):		
Color Of Hair (2 character code):		
Height (Inches/2 characters 5'-6" = 66):		
Weight (Lbs./3 characters 90 lbs = 090):		

	Fourth Family Member	Fifth Family Member
Name (Last, First, MI.):		
Sex (Female-F/Male-M):		
Relationship (2 character code):		
Social Security Number:		
DOB (yyyymmmdd/e.g.: 1951Aug09):		
Color Of Eyes (2 character code):		
Color Of Hair (2 character code):		
Height (Inches/2 characters 5'-6" = 66):		
Weight (Lbs./3 characters 90 lbs = 090):		

	Sixth Family Member	Seventh Family Member
Name (Last, First, MI.):		
Sex (Female-F/Male-M):		
Relationship (2 character code):		
Social Security Number:		
DOB (yyyymmmdd/e.g.: 1951Aug09):		
Color Of Eyes (2 character code):		
Color Of Hair (2 character code):		
Height (Inches/2 characters 5'-6" = 66):		
Weight (Lbs./3 characters 90 lbs = 090):		

Character Codes

Marital Status

ANL	Annulled
DIV	Divorced
INT	Interlocutory Decree
JSM	Joint Service Marriage
LSP	Legally Separated
MAR	Married
SGL	Single
WID	Widow or Widower

Relationship

SP	Spouse
CH	Child
SC	Stepchild
WARD	Legal Ward
PAR	Parent
PL	Parent-in-Law
SPL	Step-Parent-in-Law
URW	Unremarried Widow(er) (never remarried)
UMW	Unmarried Widow(er)

Eye Color

BR	Brown
GR	Green
BL	Blue
HZ	Hazel
BK	Black
GY	Gray
OT	Other

Hair Color

BR	Brown
GY	Gray
RD	Red
AU	Auburn
BK	Black
BN	Blonde
OT	Other

Required Documentation

- DD Form 214 Only if Sponsor or spouse is retired military
- Marriage License Only if renewing ID Card for spouse
- Birth Certificate(s) of Child(ren) Only if renewing ID Card(s) for Child(ren) (Document(s) must prove relationship)
- Birth Certificate(s) of Child(ren) and Marriage Licenses If renewing ID Card(s) for Step-children (Document(s) must prove relationship)
- College/Univ. Letter verifying full time enrollment Only if renewing ID Card(s) for Child(ren) over 21 years of age.
- Other as requested by verifying official.

Standard Form 1199A
(Rev. June 1987)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for direct deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed for will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Sufffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed Salary/Mil. Civilian Pay
- ☐ Mil. Active _____
- ☐ Mil. Retire. _____
- ☐ Mil. Survivor _____
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENRATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or record-keeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Facilities Management Division, Property & Supply Section, Room B-101, 3700 East-West Highway, Hyattsville, MD 20782 or the Office of Management and Budget, Paperwork Reduction Project (1510-0007), Washington, D.C. 20503.

PLEASE READ THIS CAREFULLY

All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

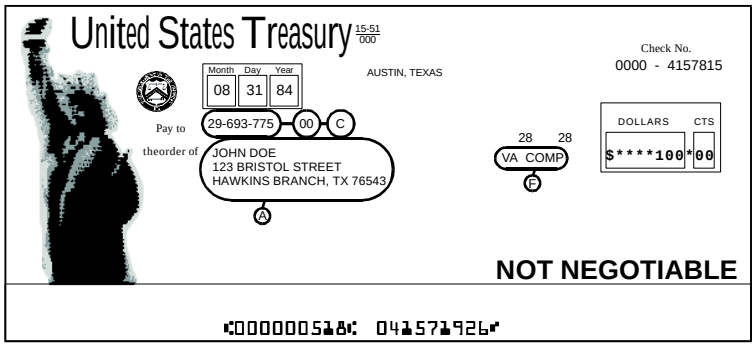
INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A, C, and F in Section 1 is printed on your government check:

Ⓐ Be sure that the payee's name is written exactly as it appears on the check. Be sure current address is shown.

Ⓒ Claim numbers and suffixes are printed here on checks beneath the date for the type of payment shown here. Check the Green Book for the location of prefixes and suffixes for other types of payments.

Ⓕ Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until canceled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete the new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

STANDARD FORM 144 (Rev. 3/92)
Office of Personnel Management
FPM Supplement 296-33

Statement of Prior Federal Service

(PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM)

Privacy Act Statement

Section 6303 of 5 U.S.C., "Annual Leave Accrual" authorizes collection of information to determine and record service that may be creditable for accrual of annual leave. Part 351.503, 5 C.F.R., "Length of Service," authorizes collection of data to determine and record service that may be creditable for reduction-in-force retention purposes.

Information about prior Federal civilian and military service is collected and maintained in your Official Personnel Folder (OPF). The information you furnish may be disclosed to other Federal agencies or Congressional or Judicial Offices in order to verify it or in connection with your application for a job, license, grant, or other benefit. It may also be disclosed to a national, state, or local law enforcement agency where there is indication of a violation or potential violation of civil or criminal law or regulation, or to another Federal agency or court when the Government is party to a suit.

Furnishing this information is voluntary; however, failure to do so may result in your not receiving credit for prior Federal service.

1. What Is Needed To Verify Prior Service

In order for your employing agency to credit your prior Federal service for benefits, such as leave accrual and reduction-in force retention, the dates of your active uniformed service and the type(s) of appointment(s) and dates of civilian service must be verified. Dates of active uniformed service are verified from the records issued by the branch of service in which you served. Dates and types of appointments to civilian positions are usually verified from Notifications of Personnel Action (Standard Form 50 or CSC- or OMP- approved exceptions thereto), and payroll records (including records of deductions made under the Civil Service Retirement System - Standard Form 2806, or the Federal Employees Retirement System - Standard Form 3100). The information on the application you submitted for the appointment you are receiving, along with the information on page 3 of this form, will be used by your agency to identify the Federal employers and periods of employment for which records must be obtained to verify the prior service.

When Notification of Personnel Action or payroll records cannot be located to verify a period of service, and the service was covered by Social Security, a detailed statement of earnings information (showing periods of employment and the name of the employer) from the Social Security Administration will be accepted as proof of service.

If no personnel, payroll, or Social Security records can be located, then your agency can accept secondary evidence of civilian employment, as explained below. When the secondary evidence you submit includes your affidavit regarding one or more periods of service, that affidavit should be made on page 2 of this form.

II. Use Of Secondary Evidence To Verify Federal Service

Secondary evidence may be considered as proof of Federal civilian service **only** when official Government records are lost, destroyed, or incomplete. Necessarily, the **burden of proof is on the person claiming service** that is not supported by official records in the custody of the U.S. Government. If you decide to claim credit for a period of service by submitting secondary evidence, it is important that you **submit all documents in your possession** that tend to prove you performed the service claimed, and that the service, if performed, was creditable for leave accrual and reduction-in-force purposes. **No credit** can be allowed for any service that is **not substantiated** by valid and conclusive secondary evidence. The following is applicable only if you are providing secondary evidence.

A. Documentary Evidence: Submit as many as possible of the documents listed in item 1 below. If your agency finds that these documents are insufficient to determine creditability, the documents listed in items 2 and 3 may be considered, but less weight will be given to such evidence.

1. Copies of official documents or letters about the service. These may be notices of appointment/ separation; notices of changes in position/salary, organization, or headquarters; travel orders; payroll cards; ID's, etc.

2. Private records such as a diary, correspondence, copies of income tax returns, employment applica- tions, credit applications, etc., that mention the Federal employer and the claimed service. Private records must have been made during or shortly after the period of service.

3. Any other documentary evidence tending to prove the service was actually performed and the starting and ending dates of the service.

B. Affidavit Evidence: If you are not able to supply copies of official documents (as described in item 1 above) that are sufficient for your agency to make a determination of creditability, you must submit affidavits from yourself and at least two other persons (preferably your supervisors) who know the facts. If you can obtain no documentary evidence (items 1, 2, and 3, above) to support your claim, you may submit these affidavits only; **however,** your claim is more likely to be rejected without supporting documents. The required affidavits are from:

-- The employee, stating as many of the details on the affidavit form on page 2 as can accurately be remembered.

-- At least two persons knowing the facts. Each person should show that he or she is in a position to know the facts sworn to, and give his or her age and mailing address.

Affidavits must be sworn to or affirmed before a notary public or other officer who is authorized by law to administer oaths.

C. Warning: Any submission may be investigated. Intentional false statements, willful concealments, or using documents you know are false, fictitious, or fraudulent is punishable by fine/imprisonment. (18 U.S.C. 1001).

EMPLOYEE AFFIDAVIT
SUBMITTED TO SUPPORT CLAIM FOR CREDIT FOR PRIOR FEDERAL CIVILIAN SERVICE

1. Name of Employee (Last, First, Middle)	2. Birthdate (Month, Day, Year)

3. Title of Position Held	4. Dates of Service (Month, Day, Year)	
	Beginning	Ending
5. Name of Employing Agency	6. Location of Employment (City and State)	
7. Pay Plan and Grade at Which Employed (e.g., GS-5, WG-8)	8. Reason for Leaving	
9. Salary Rates		
10. Funds From Which Salary Was Paid, if Known (Appropriated, Non-Appropriated, Trust Fund, etc.)		

11. Names And Current Mailing Addresses Of Persons Who Have Knowledge Of Your Employment During This Period

A	Name (First, Middle, Last)	Organizational Relationship to Employee During Period of Employment (e.g. immediate supervisor)
	Address (Street Number, City, State, ZIP Code)	

B	Name (First, Middle, Last)	Organizational Relationship to Employee During Period of Employment (e.g. immediate supervisor)
	Address (Street Number, City, State, ZIP Code)	

C	Name (First, Middle, Last)	Organizational Relationship to Employee During Period of Employment (e.g. immediate supervisor)
	Address (Street Number, City, State, ZIP Code)	

D	Name (First, Middle, Last)	Organizational Relationship to Employee During Period of Employment (e.g. immediate supervisor)
	Address (Street Number, City, State, ZIP Code)	

TO BE EXECUTED BEFORE A NOTARY PUBLIC OR ANY OTHER PERSON AUTHORIZED TO ADMINISTER OATHS

I swear (or affirm) that the above statements are true to the best of my knowledge and belief.	Signature of Employee	Date (Month, Day, Year)
SEAL	Subscribed and sworn (or affirmed) before me this _____ day of _____ (Month) 19____ at _____ (City and State)	
	Signature	Expiration date of Commission if the oath is taken by a Notary Public.

STANDARD FORM 144 (Rev. 3/92) (PAGE 3)
Office of Personnel Management
FPM Supplement 296-33

Statement of Prior Federal Service

PART I - TO BE COMPLETED BY EMPLOYEE

1. Name (Last, First, Middle Initial)	2. Birthdate (Month, Day, Year)

3. Does the application that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?	☐ YES (If "YES", check this block and then skip to item 8.)
	☐ NO (If "NO", check this block and complete items 4-8.)

4. List below your prior civilian service (Include service with the D.C. Government on appointments made before October 1, 1987).

Name and Location of Agency	FROM			TO			Type of Appointment and Work Schedule (Full-Time, Part-Time or Intermittent)
	Year	Month	Day	Year	Month	Day	

5. During periods of employment shown in Item 4, did you have a total of more than 6 months' absence without pay during any one calendar year?
☐ YES (If "YES", list the following information.)
☐ NO (If "NO", go to Item 6.)

Type If Known (L.W.O.P., Furlough, Suspension, A.W.O.L., or Place- ment in Nonpay Status From Seasonal or On-Call Employment.)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	Years	Months	Days

6. List all uniformed service below. (List active service in any branch of the Armed Forces of the United States, including active duty as a reservis and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration. Also list Merchant Marine service if it interrupted Federal civilian service.)

Branch	FROM			TO			Discharge (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	

7. Do you claim any type of veteran preference with has not been verified?

☐ No

☐ Yes - (Check one of the statements, if it applies to you.)

I claim preference as the:
☐ Spouse of a disabled veteran.
☐ Mother of a deceased or disabled veteran.
☐ Unmarried widow/widower of a veteran.

8. CERTIFICATION: The prior Federal civilian and uniformed service listed on my application and listed above constitutes my entire record of Fede employment. I have no other Federal service for which I want to claim credit.

Signature	Date (Month, Day, Year)

TO BE COMPLETED BY THE PERSONNEL OFFICE

PART II - DETERMINATION OF CREDITABLE SERVICE AND SERVICE COMPUTATION DATE FOR LEAVE PURPOSES (See FPM Chapter 630 and Supplement 296-33, S6.) NOTE: For year below, show only last two numbers; for months show numerical equivalent.

CREDITABLE SERVICE (List only periods that are creditable for leave purposes.)	(A) APPOINTMENT DATE			(B) SEPARATION DATE			NONCREDITABLE SERVICE (Explain noncreditable time listed in Column (A), such as "lost time" during military service.)
	Year	Month	Day	Year	Month	Day	
Entrance on duty date							
Total noncreditable service							
Total of appointment dates	(A)						
Total of separation dates	(B)						
SCD - Leave (A) - (B)							

PART III - DETERMINATION OF CREDITABLE SERVICE AND SERVICE DATE FOR REDUCTION-IN-FORCE PURPOSES
Complete only in cases where the amount of creditable service for reduction-in-force purposes differs from the amount creditable for leave purposes (See FPM Supplements 296-33 and 351-1.)

CREDITABLE SERVICE	(A) APPOINTMENT* DATE			(B) SEPARATION DATE			NONCREDITABLE SERVICE (Explain noncreditable time listed in Column (A), such as "lost time" during military service.)
	Year	Month	Day	Year	Month	Day	
SCD - Leave (from Part II) Additional service creditable for RIF only							
Total noncreditable service							
Total of appointment dates	(A)						
Total of separation dates	(B)						
SCD - RIF (A) - (B)*							

*Also known as "Service Date"

REMARKS

Name of Person Computing SCD(s)	Date SCD(s) Computed

FEHB
Federal Employees Health Benefits Program

Form Approved:
OMB No. 3206-0160

Employee Health Benefits Election Form

Uses for Standard Form (SF) 2809
Use this form to:

Enroll in the FEHB Program; or

Elect not to enroll in the FEHB Program (employees only); or

Change your FEHB enrollment from Self Only to Self and Family and/or from your present plan or option to another plan or option because of an event described in the table beginning on page 6; or

Change your FEHB enrollment from Self and Family to Self Only; or

Cancel your FEHB enrollment.

Who May Use SF 2809

1. Employees eligible to enroll in or currently enrolled in the FEHB Program, including temporary employees eligible under 5 U.S.C. 8906a.

Note: *Civil Service Retirement System (CSRS) and Federal Employees Retirement System (FERS) annuitants and former spouses and children of CSRS/FERS annuitants --* ***Do not use this form.*** *Instead, call the Retirement Information Office toll-free at 1-888-767-6738. Customers within the local calling distance to Washington, DC, should call 202-606-0500.*

2. Former spouses eligible to enroll in or currently enrolled in the FEHB Program under the Spouse Equity law or similar statutes.
3. Individuals eligible for temporary continuation of coverage under the FEHB Program, including:

   Former employees (who separated from service);

   Children who lose FEHB coverage; and

   Former spouses who are not eligible for FEHB under item 2 above.

Instructions for Completing SF 2809
Type or Print Firmly

Part A. You must complete this part.

Item 1. Give your last name, first name and middle initial.

Item 2. Enter your Social Security Number. (See the Privacy Act and Public Burden Statements on page 5.)

Item 3. Give your date of birth, using numbers to show the month, day, and complete year; e.g., 06/30/1998.

Item 4. Enter your permanent home mailing address.

Item 5. Place an "X" in the appropriate box.

Item 6. Place an "X" in the box that signifies your current marital status (if you are separated but not divorced, you are still married).

Item 7. Give the telephone number where you can be reached during normal business hours. Be sure to include the area code.

Part B. Complete this part to enroll or change your enrollment in the FEHB Program.

Item 1. Enter the plan name and appropriate enrollment code from the front cover of the brochure of the plan you want to be enrolled in. The enrollment code shows the plan and option you are electing and whether you are enrolling for Self Only or Self and Family.

To enroll in a Health Maintenance Organization (HMO), you must live (or in some cases work) in a geographic area specified by the carrier.

To enroll in an employee organization plan, you must be or become a member of the plan's sponsoring organization, as specified by the carrier.

Your signature in Part G authorizes deductions from your salary, annuity, or compensation to cover your cost of the enrollment you elect in this item, unless you are required to make direct payments to the employing office.

Items 2a through 2f

Complete these items only if your enrollment is for Self and Family. (If you need extra space for additional family members, list them on a separate sheet and attach.)

Item 2a. Indicate the first name and middle initial of each covered family member. Also, give the last name if different from your own.

Item 2b. Provide the ZIP code if it is different from the enrollee's ZIP code in Part A, item 4.

Item 2c. Give each dependent's date of birth, using numbers to show the month, day, and complete year; e.g., 06/30/1998.

Item 2d. Indicate *M* for male or *F* for female.

Item 2e. Provide the code which indicates the relationship of each eligible family member to you.

1. Spouse
2. Unmarried dependent child under age 22 (including an adopted child)

3. Stepchild, foster child, or recognized child born out of wedlock

4. Unmarried disabled child over age 22 incapable of self support because of a physical or mental disability that began before age 22.

Item 2f. Please provide Social Security Numbers for your dependents if available. If not available, leave blank; benefits will not be withheld. (See Privacy Act Statement on page 5.)

Family Members Eligible for Coverage

Unless you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment include your spouse and your unmarried dependent children under age 22. Eligible children include your legitimate or adopted children; and recognized children born out of wedlock, stepchildren or foster children, if they live with you in a regular parent-child relationship. A recognized child born out of wedlock also may be included if a judicial determination of support has been obtained or you show that you provide regular and substantial support for the child.

Other relatives (for example, your parents) are **not** eligible for coverage even if they live with you and are dependent upon you.

If you are a former spouse or survivor annuitant, family members eligible for coverage under your Self and Family enrollment are the unmarried dependent natural or adopted children under age 22 of both you and your former or deceased spouse.

Children whose marriage ends before they reach age 22 become eligible for coverage under your Self and Family enrollment from the date the marriage ends until they reach age 22.

In some cases, an unmarried, disabled child who is 22 years old or older is eligible for coverage under your Self and Family enrollment if you provide adequate medical certification of a mental or physical handicap that existed before his or her 22nd birthday and renders the child incapable of self-support.

Note: *Your employing office (see definition under Where to Obtain FEHB Guides and Brochures on page 3) can give you additional details about family member eligibility including the documentation required for coverage of a disabled child age 22 or older.*

Item 3a. Place an "X" in the appropriate box. If you answer "Yes," enter the name of the policyholder in the space provided and complete item 3b.

Item 3b. If you or your spouse has Medicare, check the Medicare box and show which Parts each of you have.

If you or any covered family member has TRICARE (including CHAMPUS), check that box.

If you or any covered family member has any other group insurance, check that box and give the name of the insurance.

Part C. You must complete this part if you are changing your enrollment.

Item 1. Enter the name of the plan you are in now.

Item 2. Enter your present enrollment code.

Part D. You must complete this part if you are newly enrolling or changing based on an event listed in the Table of Permissible Changes in Enrollment beginning on page 6. Do not complete this part if you are cancelling or changing from Self and Family to Self Only.

Item 1. Enter the event code that permits you to enroll or change, from the table beginning on page 6.

Item 2. Enter the date of the event that permits you to enroll or change, using numbers to show month, day, and complete year; e.g., 06/30/1998. For initial enrollment, enter the date you became eligible to enroll (for example, the date your appointment began). For Open Season changes, enter the date on which the Open Season begins.

Part E. Place an "X" in the box provided only if you are an employee and you do not wish to enroll in the FEHB Program. **(Be sure to read the information about electing not to enroll on page 4.)**

Part F. Place an "X" in the box provided only if you wish to cancel your FEHB enrollment. Also enter your present enrollment code in the space provided. **(Be sure to read the information about cancelling your enrollment on page 4.)**

Part G. You must complete this part.

Item 1. Sign your name. Do not print.

Item 2. Enter the date you sign, using numbers to show the month, day and complete year; e.g., 06/30/1998.

Leave ***Part H*** and ***Remarks*** section blank. They are for agency use only.

If You Are Registering for Someone Else

If you are registering for someone else under a written authorization from him or her to do so, sign your name in Part G and attach the written authorization.

If you are registering for a former spouse eligible for coverage under the Spouse Equity provisions or for an individual eligible for temporary continuation of coverage as his or her court-appointed guardian, sign your name in Part G and attach evidence of your court-appointed guardianship.

Guides to Federal Employees Health Benefits Plans (FEHB Guides) and Plan Brochures

FEHB Guides contain enrollment, plan, and rate information. Be sure you have the correct guide for your enrollment category since more than one guide is issued. The different categories are:

Employees, non-Postal or Postal

Annuitants in CSRS or FERS or other retirement systems

Temporary Continuation of Coverage enrollees and former spouses under Spouse Equity

Individuals receiving compensation from the Office of Workers' Compensation Programs

Temporary employees eligible for FEHB under 5 U.S.C. 8906a

Visually impaired employees

FEHB Plan brochures contain detailed information about plan benefits and the contractual description of coverage.

Where to Obtain FEHB Guides and Brochures

Your plan will send you its brochure before the beginning of each contract year.

FEHB Guides and plan brochures are available from your employing office.

"Employing office" means the office of an agency or retirement system that is responsible for health benefits actions for an employee, annuitant, former spouse eligible for coverage under the Spouse Equity provisions, or individual eligible for temporary continuation of coverage (TCC).

You can also get copies of plan brochures by contacting the plans directly at the telephone numbers shown in the FEHB Guide. The FEHB Guide also shows which plans have their own website.

The FEHB Guide, plan brochures, and other information, including links to plan websites, are available on the World Wide Web. Visit our website at **http://www.opm.gov/insure**.

Employee Express

Employee Express is an automated system that allows some Federal employees to make changes using a touch-tone telephone, a personal computer or computer kiosk instead of a form. If you are not sure whether you can use Employee Express, call your employing office.

Dual Enrollment

Normally, you are not eligible to enroll if you are covered as a family member under someone else's enrollment in the FEHB Program. However, such dual enrollments may be permitted under certain circumstances in order to:

Protect the interests of children who otherwise would lose coverage as family members, or

Enable an employee who is under age 22 and covered under a parent's enrollment and becomes the parent of a child to enroll for Self and Family coverage.

No person (enrollee or family member) is entitled to receive benefits under more than one enrollment in the Program. (Each enrollee must notify his or her plan of the names of the persons to be covered under his or her enrollment who are not covered under the other enrollment.)

Temporary Continuation of Coverage (TCC)

While the employing office notifies a former employee of his or her eligibility for temporary continuation of coverage, the employing office must be notified when a child or former spouse becomes eligible.

For the eligible child of an enrollee, the enrollee must notify the employing office within 60 days after the qualifying event occurs; e.g., child reaches age 22.

For the eligible former spouse of an enrollee, the enrollee or the former spouse must notify the employing office within 60 days after the former spouse's change in status; e.g., the date of the divorce.

An individual eligible for temporary continuation of coverage who wants to continue FEHB coverage may choose any plan (for which he or she is eligible), option, and type of enrollment. The time limits for a former employee, child, or former spouse to file the SF 2809 with the employing office appear in event number 4A in the table on page 8.

Note: *If someone other than the enrollee notifies the employing office of the child's eligibility for temporary continuation of coverage within the specified time period, the child's opportunity to file the SF 2809 ends 60 days after the qualifying event. If someone other than the enrollee or the former spouse notifies the employing office of the former spouse's eligibility for continued coverage within the specified time period, the former spouse's opportunity to file the SF 2809 ends 60 days after the change in status.*

Effective Dates

Except for open season, most enrollments and changes of enrollments are effective on the first day of the pay period after the employing office receives the SF 2809 or other appropriate request. Your employing office can give you the specific date on which your enrollment or enrollment change will take effect.

Note 1: *If you are changing your enrollment from Self and Family to Self Only so that your spouse can enroll for Self Only, you should coordinate the effective date of your spouse's enrollment with the effective date of your enrollment change to avoid a gap in your spouse's coverage.*

Note 2: *If you are cancelling your enrollment and intend to be covered under someone else's enrollment at the time you cancel, you should coordinate the effective date of your cancellation with the effective date of your new coverage to avoid a gap in your coverage.*

Cancellation of Enrollment

You may cancel your enrollment at any time. (If you are a United States Postal Service employee, consult your employing office or information provided by your agency.) However, if you cancel, neither you nor any family member covered by your enrollment are entitled to a 31-day temporary extension of coverage, or to convert to an individual, nongroup policy. Moreover, family members who lose coverage because of your cancellation are not eligible for temporary continuation of coverage. (Be sure to read the additional information below about cancelling your enrollment.)

Employees Who Elect Not to Enroll or Who Cancel Their Enrollment

To be eligible for an FEHB enrollment after you retire, you must retire:

Under a retirement system for Federal civilian employees, and

On an immediate annuity.

In addition, you must be currently enrolled in a plan under the FEHB Program and must have been enrolled (or covered as a family member) in a plan under the Program for:

The 5 years of service immediately before retirement (i.e., commencing date of annuity entitlement), or

If fewer than 5 years, all service since your first opportunity to enroll. (Generally, your first opportunity to enroll is within 60 days after your first appointment [in your Federal career] to a position under which you are eligible to enroll under conditions that permit a Government contribution toward the enrollment.)

If you do not enroll at your first opportunity or if you cancel your enrollment, you may later enroll or reenroll only under the circumstances explained in the table beginning on page 6. Some employees delay their enrollment or reenrollment until they are nearing 5 years before retirement in order to qualify for FEHB coverage as a retiree; however, there is always the risk that they will retire earlier than expected and not be able to meet the 5-year requirement for continuing FEHB coverage into retirement. Please understand that when you elect not to enroll or cancel your enrollment **you are voluntarily accepting this risk.** An alternative would be to enroll in or change to a lower cost plan so that you meet the requirements for continuation of your FEHB enrollment after retirement.

Note for temporary employees eligible for FEHB under 5 U.S.C. 8906a: *Your decision not to enroll or to cancel your enrollment will **not** affect your future eligibility to continue FEHB enrollment after retirement.*

Annuitants Who Cancel Their Enrollment

Generally, you cannot reenroll as an annuitant unless you are continuously covered as a family member under another person's enrollment in the FEHB Program during the period between your cancellation and reenrollment. Your employing office can advise you on events that allow eligible annuitants to reenroll.

If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your FEHB enrollment because you are enrolling in a Medicare HMO, or Medicaid or similar State-sponsored program, you can reenroll in the FEHB Program if your coverage ends. If your coverage ends **involuntarily,** you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends **voluntarily** because you disenroll, you can reenroll during the next open season.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Former Spouses (Spouse Equity) Who Cancel Their Enrollment

Generally, if you cancel your enrollment in the FEHB Program, you cannot reenroll as a former spouse. However, if you stop the enrollment because you acquire other FEHB coverage, your right to FEHB coverage under the spouse equity provisions continues. You may reenroll as a former spouse when the other FEHB coverage ends.

If you cancel your enrollment because you are covered under another FEHB enrollment, you can reenroll from 31 days before through 60 days after you lose that coverage under the other enrollment.

If you cancel your FEHB enrollment because you are enrolling in a Medicare HMO, or Medicaid or similar State-sponsored program, you can reenroll in the FEHB Program if your coverage ends. If your coverage ends **involuntarily,** you can reenroll 31 days before through 60 days after loss of coverage. If your coverage ends **voluntarily** because you disenroll, you can reenroll during the next open season.

If you cancel your enrollment for any other reason, you cannot later reenroll, and you and any family members covered by your enrollment are not entitled to a 31-day temporary extension of coverage or to convert to an individual policy.

Temporary Continuation of Coverage Enrollees Who Cancel Their Enrollment

If you cancel your TCC enrollment, you cannot reenroll. Your family members who lose coverage because of your cancellation cannot enroll for TCC in their own right nor can they convert to a nongroup policy. However, family members who are Federal employees or annuitants may enroll in the FEHB Program when you cancel your coverage if they are eligible for FEHB coverage in their own right.

Note 1: *If you become covered by a regular enrollment in the FEHB Program, either in your own right or under the enrollment of someone else, your TCC enrollment is suspended. You will need to send documentation of the new enrollment to the employing office maintaining your TCC enrollment so that they can stop the TCC enrollment. If your new FEHB coverage stops before the TCC enrollment would have expired, the TCC enrollment can be reinstated for the remainder of the original eligibility period (18 months for separated employees).*

Note 2: *Former spouses (spouse equity) and temporary continuation of coverage enrollees who fail to pay their premiums within specified time frames are considered to have voluntarily cancelled their enrollment.*

Explanation of Table of Permissible Changes in Enrollment

The table on pages 6 through 9 illustrates when an employee, former spouse, or person eligible for TCC may enroll or change enrollment. The table shows those permissible events that are found in the regulations at 5 CFR Part 890.

The table has been organized by enrollee category. Each category is designated by a number, which identifies the enrollee group, as follows:

1 Employees

3 Former spouses

4 TCC enrollees

Note: *Category 2 has been reserved for annuitants (other than CSRS/FERS annuitants), including individuals receiving monthly compensation from the Office of Workers' Compensation Programs, who will be using another edition of this form, SF 2809-1.*

Following each number is a letter, which identifies a specific permissible event; for example, the event code "1A" refers to an employee's initial opportunity to enroll.

At Part D of the SF 2809, Health Benefits Election Form, you must designate your two-character event code (for example, 1A) and the date of the event using numbers to show month, day, and complete year; e.g., 06/30/1998.

Privacy Act Statement

The information you provide on this form is needed to document your enrollment in the Federal Employees Health Benefits Program under Chapter 89, title 5, U.S. Code. This information will be shared with the health insurance carrier you select so that it may (1) identify your enrollment in the plan, (2) verify your and/or your family's eligibility for payment of a claim for health benefits services or supplies, and (3) coordinate payment of claims with other carriers with whom you might also make a claim for payment of benefits. This information may be disclosed to other Federal agencies or Congressional offices which may have a need to know it in connection with your application for a job, license, grant, or other benefit. It may also be shared and is subject to verification, via paper, electronic media, or through the use of computer matching programs, with national, state, local, or other charitable or social security administrative agencies to determine and issue benefits under their programs or to obtain information necessary for determination or continuation of benefits under this program. In addition, to the extent this information indicates a possible violation of civil or criminal law, it may be shared and verified, as noted above, with an appropriate Federal, state, or local law enforcement agency.

While the law does not require you to supply all the information requested on this form, doing so will assist in the prompt processing of your enrollment.

We request that you provide your Social Security Number so that it may be used as your individual identifier in the Federal Employees Health Benefits Program. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a Social Security Number or tax identification number. This is an amendment to title 31, Section 7701. Failure to furnish the requested information may result in OPM's inability to ensure the prompt payment of your and/or your family's claims for health benefits services or supplies.

Agencies other than the Office of Personnel Management may have further routine uses for disclosure of information from the records system in which they file copies of this form. If this is the case, they should provide you with any such uses which are applicable at the time they ask you to complete this form.

Public Burden Statement

We think this form takes an average of 30 minutes to complete, including the time for reviewing instructions, getting the needed data, and reviewing the completed form. Send comments regarding our time estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management, Reports and Forms Manager, (3206-0160), Washington, D.C. 20415-7900. The OMB number, 3206-0160 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Table of Permissible Changes in Enrollment for SF 2809

Enrollment May Be Cancelled or Changed From Family to Self Only at Any Time*

Events That Permit Enrollment or Change		*Change Permitted*			*Time Limits*
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
1	**EMPLOYEE**				
1A	Initial opportunity to enroll.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1B	Open Season.	Yes	Yes	Yes	As announced by OPM.
1C	Change in family status; for example: marriage, birth or death of family member, adoption, legal separation, or divorce.	Yes	Yes	Yes	From 31 days before through 60 days after event.
1D	Change in employment status; for example: • Reemployment after a break in service of more than three days; • Return to pay status following loss of coverage due to expiration of 365 days of LWOP status or termination of coverage during LWOP; • Return to pay sufficient to make withholdings after termination of coverage during a period of insufficient pay; • Restoration to civilian position after serving in uniformed services; • Change from temporary appointment to appointment that entitles employee receipt of Government contribution; • Change to or from part-time career employment.	Yes	Yes	Yes	Within 60 days of employment status change.
1E	Separation from Federal employment when the employee or employee's spouse is pregnant.	Yes	Yes	Yes	Enrollment or change must occur during final pay period of employment.
1F	Transfer from a post of duty within the United States to a post of duty outside the United States, or reverse.	Yes	Yes	Yes	From 31 days before leaving old post through 60 days after arriving at new post.
1G	Employee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self only of the covering enrollment; • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	Yes	Yes	Yes	From 31 days before through 60 days after loss of coverage.
1H	Employee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.

* If you are a United States Postal Service employee, these rules may be different. Consult your employing office or information provided by your agency.

Events That Permit Enrollment or Change		*Change Permitted*			*Time Limits*
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
1I	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area through 180 days after arriving in the new commuting area.
1J	Employee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside the area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
1K	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.
1L	Temporary employee completes one year of continuous service in accordance with 5 U.S.C. Section 8906a.	Yes	N/A	N/A	Within 60 days after becoming eligible.
1M	Salary of temporary employee insufficient to make withholdings for plan in which enrolled.	N/A	No	Yes	Within 60 days after receiving notice from employing office.
3	**FORMER SPOUSE UNDER THE SPOUSE EQUITY PROVISIONS**				
3A	Initial opportunity to enroll, Former spouse must be eligible to enroll under the authority of the Civil Service Retirement Spouse Equity Act of 1984 (P.L. 98-615), as amended, the Intelligence Authorization Act of 1986 (P.L. 99-569), or the Foreign Relations Authorization Act, Fiscal Years 1988 and 1989 (P.L. 100-204).	Yes	N/A	N/A	Generally, must apply within 60 days after dissolution of marriage. However, if a retiring employee elects to provide a former spouse annuity or insurable interest annuity for the former spouse, the former spouse must apply within 60 days after OPM's notice of eligibility for FEHB. May enroll any time after employing office establishes eligibility.
3B	Open season.	No	Yes*	Yes	As announced by OPM.
3C	Change in family status based on addition of family members who are also eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after change in family status.
3D	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later was **involuntarily** disenrolled from the Medicare HMO, Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	From 31 days before through 60 days after disenrollment.

* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.

Events That Permit Enrollment or Change		*Change Permitted*			*Time Limits*
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Self and Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
3E	Reenrollment of former spouse who cancelled FEHB enrollment to enroll in a Medicare-sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program and who later **voluntarily** disenrolls from the Medicare-sponsored Coordinated Care Plan (Medicare HMO), Medicaid, or similar State-sponsored program.	May Reenroll	N/A	N/A	During open season.
3F	Former spouse or eligible child loses FEHB coverage due to termination, cancellation, or change to self only of the covering enrollment.	Yes	Yes	Yes	From 31 days before through 60 days after date of loss of coverage.
3G	Enrolled former spouse or eligible child loses coverage under another group insurance plan; for example: • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program (but see 3D and 3E); • Loss of coverage under a non-Federal health plan.	N/A	Yes	Yes	From 31 days before through 60 days after loss of coverage.
3H	Former spouse or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
3I	Former spouse or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
3J	On becoming eligible for Medicare (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning the 30th day before becoming eligible for Medicare.
3K	Former spouse's annuity is insufficient to make FEHB withholdings for plan in which enrolled.	No	No	Yes	Retirement System will advise former spouse of options.
4	**TEMPORARY CONTINUATION OF COVERAGE (TCC) FOR ELIGIBLE FORMER EMPLOYEES, FORMER SPOUSES, AND CHILDREN.**				
4A	Opportunity to enroll for continued coverage under TCC provisions: • Former employee • Former spouse • Child who ceases to qualify as a family member	 Yes Yes Yes	 Yes N/A N/A	 Yes N/A N/A	Within 60 days after the qualifying event, or receiving notice of eligibility, whichever is later.
4B	Open season: • Former employee • Former spouse • Child who ceases to qualify as a family member	 No No No	 Yes Yes* Yes	 Yes Yes Yes	As announced by OPM.

* Former spouse may change to self and family only if family members are also eligible family members of the employee or annuitant.

Events That Permit Enrollment or Change		*Change Permitted*			*Time Limits*
Code	*Event*	*From Not Enrolled to Enrolled*	*From Self Only to Family*	*From One Plan or Option to Another*	*When You Must File Health Benefits Election Form With Your Employing Office*
4C	Change in family status (except former spouse); for example, marriage, birth or death of family member, adoption, legal separation, or divorce.	No	Yes	Yes	From 31 days before through 60 days after event.
4D	Change in family status of former spouse, based on addition of family members who are eligible family members of the employee or annuitant.	No	Yes	Yes	From 31 days before through 60 days after event.
4E	Reenrollment of a former employee, former spouse, or child whose TCC enrollment was terminated because of other FEHB coverage and who loses the other FEHB coverage before the TCC period of eligibility (18 or 36 months) expires.	May Reenroll	N/A	N/A	From 31 days before through 60 days after the event. Enrollment is retroactive to the date of the loss of the other FEHB coverage.
4F	Enrollee or eligible family member loses coverage under FEHB or another group insurance plan; for example: • Loss of coverage under another FEHB enrollment due to termination, cancellation, or change to self only of the covering enrollment (but see event 4E); • Loss of coverage under another federally-sponsored health benefits program; • Loss of coverage due to termination of membership in the employee organization sponsoring the FEHB plan; • Loss of coverage under Medicaid or similar State-sponsored program; • Loss of coverage under a non-Federal health plan.	No	Yes	Yes	From 31 days before through 60 days after loss of coverage.
4G	Enrollee or eligible family member loses coverage due to the discontinuance, in whole or part, of an FEHB plan.	N/A	Yes	Yes	During open season, unless OPM sets a different time.
4H	Enrollee or covered family member in a Health Maintenance Organization (HMO) moves or becomes employed outside the geographic area from which the carrier accepts enrollments, or if already outside this area, moves or becomes employed further from this area.	N/A	Yes	Yes	Upon notifying the employing office of the move or change of place of employment.
4I	On becoming eligible for Medicare. (This change may be made only once in a lifetime.)	N/A	No	Yes	At any time beginning on the 30th day before becoming eligible for Medicare.

Health Benefits Election Form

Federal Employees Health Benefits Program

For **Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

Form Approved:
OMB No. 3206-0160

- *Complete Parts A and G, and Parts B, C, D, E, and F as applicable.*
- *Type or print firmly*
- *Sign and date in Part G*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. Your home mailing address *(include ZIP code)*
5. Sex ☐ Male ☐ Female
6. Are you now married? ☐ Yes ☐ No
7. Daytime telephone number *(include area code)* ( )

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan — Enrollment code ☐☐☐

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No ☐ Yes ☐ → Complete 3b

Name of policyholder *(last, first, middle initial)*

3b. Type of insurance ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including CHAMPUS) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name
2. Present Plan enrollment code → ☐☐☐

Part D - *Event*

1. Event code that permits change *(see Table of Permissible Changes)* ☐☐
2. Date of event that permits change *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part E - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

Part F - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code ☐☐☐

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

Part G - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part H - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*
2. Date received in employing office *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
3. Effective date of action *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. SF 2811 report number
5. Payroll office number
6. Payroll contact and telephone number *(including area code)* ( )
7. Personnel contact and telephone number *(including area code)* ( )
8. Signature of authorized agency official and telephone number *(including area code)* ( )

Remarks

Health Benefits Election Form

Federal Employees Health Benefits Program

For **Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

Form Approved:
OMB No. 3206-0160

- *Complete Parts A and G, and Parts B, C, D, E, and F as applicable.*
- *Type or print firmly*
- *Sign and date in Part G*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. Your home mailing address *(include ZIP code)*
5. Sex ☐ Male ☐ Female
6. Are you now married? ☐ Yes ☐ No
7. Daytime telephone number *(include area code)* ( )

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan — Enrollment code ☐☐☐

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No ☐ Yes ☐ → Complete 3b

Name of policyholder *(last, first, middle initial)*

3b. Type of insurance ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including CHAMPUS) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name
2. Present Plan enrollment code → ☐☐☐

Part D - *Event*

1. Event code that permits change *(see Table of Permissible Changes)* ☐☐
2. Date of event that permits change *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part E - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

Part F - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code ☐☐☐

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

Part G - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part H - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*
2. Date received in employing office *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
3. Effective date of action *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. SF 2811 report number
5. Payroll office number
6. Payroll contact and telephone number *(including area code)* ( )
7. Personnel contact and telephone number *(including area code)* ( )
8. Signature of authorized agency official and telephone number *(including area code)* ( )

Remarks

Health Benefits Election Form

Federal Employees Health Benefits Program

For **Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

Form Approved:
OMB No. 3206-0160

- *Complete Parts A and G, and Parts B, C, D, E, and F as applicable.*
- *Type or print firmly*
- *Sign and date in Part G*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. Your home mailing address *(include ZIP code)*
5. Sex ☐ Male ☐ Female
6. Are you now married? ☐ Yes ☐ No
7. Daytime telephone number *(include area code)* ( )

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan — Enrollment code

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No ☐ Yes ☐ → Complete 3b

Name of policyholder *(last, first, middle initial)*

3b. Type of insurance ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including CHAMPUS) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name
2. Present Plan enrollment code →

Part D - *Event*

1. Event code that permits change *(see Table of Permissible Changes)*
2. Date of event that permits change *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part E - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

Part F - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

Part G - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part H - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*
2. Date received in employing office *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
3. Effective date of action *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. SF 2811 report number
5. Payroll office number
6. Payroll contact and telephone number *(including area code)* ( )
7. Personnel contact and telephone number *(including area code)* ( )
8. Signature of authorized agency official and telephone number *(including area code)* ( )

Remarks

Health Benefits Election Form

Federal Employees Health Benefits Program

For **Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

Form Approved:
OMB No. 3206-0160

- *Complete Parts A and G, and Parts B, C, D, E, and F as applicable.*
- *Type or print firmly*
- *Sign and date in Part G*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. Your home mailing address *(include ZIP code)*
5. Sex ☐ Male ☐ Female
6. Are you now married? ☐ Yes ☐ No
7. Daytime telephone number *(include area code)* ( )

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan — Enrollment code ☐☐☐

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No ☐ Yes ☐ → Complete 3b

Name of policyholder *(last, first, middle initial)*

3b. Type of insurance ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including CHAMPUS) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name
2. Present Plan enrollment code → ☐☐☐

Part D - *Event*

1. Event code that permits change *(see Table of Permissible Changes)* ☐☐
2. Date of event that permits change *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part E - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

Part F - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code ☐☐☐

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

Part G - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part H - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*
2. Date received in employing office *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
3. Effective date of action *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. SF 2811 report number
5. Payroll office number
6. Payroll contact and telephone number *(including area code)* ( )
7. Personnel contact and telephone number *(including area code)* ( )
8. Signature of authorized agency official and telephone number *(including area code)* ( )

Remarks

Health Benefits Election Form

Federal Employees Health Benefits Program

For **Employees, Former Spouses Under the Spouse Equity Law, and Individuals Eligible for Temporary Continuation of Coverage**

Form Approved:
OMB No. 3206-0160

- *Complete Parts A and G, and Parts B, C, D, E, and F as applicable.*
- *Type or print firmly*
- *Sign and date in Part G*

Do not separate the copies. Your employing office will certify the completed form and return your copy to you.

Part A - *Fill in this part.*

1. Name *(last, first, middle initial)*
2. Social Security Number
3. Date of birth *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. Your home mailing address *(include ZIP code)*
5. Sex ☐ Male ☐ Female
6. Are you now married? ☐ Yes ☐ No
7. Daytime telephone number *(include area code)* ( )

Part B - *Fill in this part if you wish to enroll or change your enrollment in the Federal Employees Health Benefits (FEHB) Program.*

1. I elect to enroll in a health benefits plan as shown below. *(Copy the information requested below from front cover of brochure of the plan you select.)*

Name of plan — Enrollment code

2a. Names of family members *(last, first, middle initial)*	2b. ZIP code	2c. Date of birth *(mo., day, yr.)*	2d. Sex	2e. Relationship "code"	2f. Social Security Number *(see instructions)*
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			
		___ ___/___ ___/___ ___ ___ ___			

3a. Do you, your spouse or any other eligible family members have any group health insurance coverage other than the FEHB plan in which you are now enrolling or enrolled? No ☐ Yes ☐ → Complete 3b

Name of policyholder *(last, first, middle initial)*

3b. Type of insurance ☐ Medicare *You* ☐ A ☐ B *Your spouse* ☐ A ☐ B ☐ TRICARE (Including CHAMPUS) ☐ Other *(specify name)*

Part C - *Fill in this part, as well as PART B, to change enrollment.*

1. Present Plan name
2. Present Plan enrollment code →

Part D - *Event*

1. Event code that permits change *(see Table of Permissible Changes)*
2. Date of event that permits change *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part E - *Employees Only*

Place an "X" in the box below if you wish NOT TO ENROLL in the FEHB Program.

☐ I elect not to enroll in the Federal Employees Health Benefits Program.

My signature in PART G certifies that I have read and understand the information on page 4 regarding this election.

Part F - *Cancellation*

Place an "X" in the box below if you wish to CANCEL your enrollment.

Present Plan enrollment code

☐ I elect to cancel my enrollment in the Federal Employees Health Benefits Program. I am currently enrolled under the code shown above.

My signature in PART G certifies that I have read the information in the instructions on page 4 regarding cancellation of enrollment and that I understand that I must meet the 5-year requirement to qualify for FEHB coverage after retirement.

Part G - *Fill in this part.*

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___

Part H - *To be completed by agency*

1. Name and address of employing office *(include ZIP code)*
2. Date received in employing office *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
3. Effective date of action *(mo., day, yr.)* ___ ___/___ ___/___ ___ ___ ___
4. SF 2811 report number
5. Payroll office number
6. Payroll contact and telephone number *(including area code)* ( )
7. Personnel contact and telephone number *(including area code)* ( )
8. Signature of authorized agency official and telephone number *(including area code)* ( )

Remarks

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date

Copy 1 - To Enrollee

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date

Copy 2 - To Insurance Carrier

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below. (**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date

Copy 3 - To Payroll Office

Notice of Change in Health Benefits Enrollment

Part A - Identifying Information

1. Name *(Last, first, middle initial)*	2. Date of birth	3. Social security number
4. Home address *(including ZIP Code)*	5. Payroll office number	6. Enrollment code number
	7. SF 2811 Report number	8. Date this action becomes effective

Only the item that is checked below affects your enrollment. Read that item carefully and follow any pertinent instructions. Keep this form for your records.

Part B - Termination

☐ Your enrollment terminates on the date in Part A, item 8, above. However, your coverage is extended for 31 days after that date.

Important Notice: **You have the right to convert to an individual (nongroup) contract with the carrier of your plan. You also may have the right to temporarily continue your group coverage.** See **Part B - Termination** on the back of this form for information about 31-day extension of coverage, conversion, and temporary continuation of coverage.

If termination is due to death of enrollee enter date of death — Date of death (mo, dy, yr)

Part C - Transfer In

☐ The new Payroll Office (or Retirement System) shown in Part H below has accepted transfer of this enrollment and will continue it.

Part D - Reinstatement

☐ Your enrollment has been reinstated effective on the date in Part A, item 8, above.

Part E - Change in Name of Enrollee

☐ The name under which this enrollment is carried has been changed to:

Name — Date of birth

Address (including ZIP Code) if different from Part A, item 4, above.

Part F - Change in Enrollment - Survivor Annuitant

☐ Your enrollment has been changed from family coverage to self only. Your plan will send you a new identification card. Your new enrollment code number is shown below.
(**Note:** This item is completed by Retirement Systems only.)

New Enrollment Code Number

Part G - Remarks

Part H - Date of Notice

Note: Instructions for Employing Offices are on the back of Copy 4 of this form.

Name and address of agency *(including ZIP Code)*	Personnel contact and telephone number
	Payroll contact and telephone number
Signature of authorized agency official	Date

Copy 4 - For Official Personnel Folder

STANDARD FORM 61
Revised June 1986
U.S. Office of Personnel Management
FPM Chapter 296
61-108

APPOINTMENT AFFIDAVITS

_____ _____
(Position to which appointed) *(Date of appointment)*

_____ _____ _____
(Department or agency) *(Bureau or Division)* *(Place of employment)*

I, _____, do solemnly swear (or affirm) that—

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____
(Signature of appointee)

Subscribed and sworn (or affirmed) before me this _____ day of _____, 19_____,

at _____ _____
(City) *(State)*

[SEAL]

_____
(Signature of officer)

Commission expires _____ _____
(Title)

(If by a Notary Public, the date of expiration of his/her Commission should be shown)

NOTE.—*The oath of office must be administered by a person specified in 5 U.S.C. 2903. The words "So help me God" in the oath and the word "swear" wherever it appears above should be stricken out when the appointee elects to affirm rather than swear to the affidavits; only these words may be stricken and only when the appointee elects to affirm the affidavits.*

NSN 7540-00-634-4015 * U.S Government Printing Office1992- 321-950/69047 Prior Edition Usable

EMPLOYEE CERTIFICATION

UNITED STATES RESIDENCY

I certify that

- ❑ I have lived in the United States or a U.S. territory, possession, or protectorate, for at least 12 months prior to receiving the Offer of Employment for this position.

OR

- ❑ I am transferring from another overseas Government agency or activity **AND** am receiving, or was eligible to receive, LQA (i.e., resided in Government quarters in lieu of receiving LQA) at that agency/activity **AND** was originally recruited from the United States as a civilian employee

****

EMPLOYEE CERTIFICATION

LOCAL HIRE

I certify that

my residence in the overseas area to which this quarters allowance applies is due to employment by the U.S. government **and**

that prior to this appointment, I was recruited in the United States, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, the former Canal Zone, or a possession of the United States, by:

(Check one of the following)

- ❑ The U.S. government, including the U.S. Armed Forces,
- ❑ A U.S. firm, organization, or interest (includes contractors),
- ❑ An international organization in which the U.S. government participates, or
- ❑ A foreign government,

and that employer provided for my return transportation to the United States, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, the former Canal Zone, or a possession of the United States.

I agree to provide written documentation of the above employment as required by the servicing personnel organization.

Employee Statement and Signature: The information provided in this statement is true and correct to the best of my knowledge and belief. I understand that if I provide false information to obtain this allowance I will be required to reimburse the government for any amount I may have received; that I will be subject to disciplinary action that may result in termination of my employment; and that I may be subject to criminal action.

_____ _____

(Employee Signature) **(Date)**

_____

(Employee Printed Name)

This form is subject to the Privacy Act of 1974 (5 USC 552a). The information requested will be used to determine eligibility for living quarters allowance. Furnishing all requested information will facilitate the eligibility determination, and the effects of not providing all or part of the requested information may delay the process or result in an unfavorable decision.

Form W-4 (2000)

Purpose. Complete Form W-4 so your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7, and sign the form to validate it. Your exemption for 2000 expires February 16, 2001.

Note: *You cannot claim exemption from withholding if (1) your income exceeds $700 and includes more than $250 of unearned income (e.g., interest and dividends) and (2) another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. They will help you figure the number of withholding allowances you are entitled to claim. **However, you may claim fewer (or zero) allowances.**

Child tax and higher education credits. For details on adjusting withholding for these and other credits, see **Pub. 919,** How Do I Adjust My Tax Withholding?

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using **Form 1040-ES,** Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 prepared for the highest paying job and zero allowances are claimed for the others.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2000. Get Pub. 919 especially if you used the **Two-Earner/Two-Job Worksheet** on page 2 and your earnings exceed $150,000 (Single) or $200,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter -0- if you are married and have either a working spouse or more than one job. (Entering -0- may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____

G **Child Tax Credit:**
- If your total income will be between $18,000 and $50,000 ($23,000 and $63,000 if married), enter "1" for each eligible child.
- If your total income will be between $50,000 and $80,000 ($63,000 and $115,000 if married), enter "1" if you have two eligible children, enter "2" if you have three or four eligible children, or enter "3" if you have five or more eligible children **G** _____

H Add lines A through G and enter total here. **Note:** *This may be different from the number of exemptions you claim on your tax return.* ► **H** _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single,** have **more than one job** and your combined earnings from all jobs exceed $34,000, OR if you are **married** and have a **working spouse or more than one job** and the combined earnings from all jobs exceed $60,000, see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **For Privacy Act and Paperwork Reduction Act Notice, see page 2.**

OMB No. 1545-0010
2000

1 Type or print your first name and middle initial / Last name		**2** Your social security number
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** *If married, but legally separated, or spouse is a nonresident alien, check the Single box.*	
City or town, state, and ZIP code	**4** If your last name differs from that on your social security card, check here. **You must call 1-800-772-1213 for a new card** . . . ► ☐	

5	Total number of allowances you are claiming (from line **H** above **OR** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2000, and I certify that I meet **BOTH** of the following conditions for exemption: ● Last year I had a right to a refund of **ALL** Federal income tax withheld because I had **NO** tax liability **AND** ● This year I expect a refund of **ALL** Federal income tax withheld because I expect to have **NO** tax liability. If you meet both conditions, write "EXEMPT" here . . . . . ►	**7**

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's signature
(Form is not valid unless you sign it) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number

Deductions and Adjustments Worksheet

Note: *Use this worksheet only if you plan to itemize deductions or claim adjustments to income on your 2000 tax return.*

1	Enter an estimate of your 2000 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2000, you may have to reduce your itemized deductions if your income is over $128,950 ($64,475 if married filing separately). See **Worksheet 3** in Pub. 919 for details.)	**1**	$
2	Enter: { $7,350 if married filing jointly or qualifying widow(er); $6,450 if head of household; $4,400 if single; $3,675 if married filing separately }	**2**	$
3	**Subtract** line 2 from line 1. If line 2 is greater than line 1, enter -0-	**3**	$
4	Enter an estimate of your 2000 adjustments to income, including alimony, deductible IRA contributions, and student loan interest	**4**	$
5	**Add** lines 3 and 4 and enter the total (Include any amount for credits from **Worksheet 7** in Pub. 919.)	**5**	$
6	Enter an estimate of your 2000 nonwage income (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. Enter the result, but not less than -0-	**7**	$
8	**Divide** the amount on line 7 by $3,000 and enter the result here. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	**9**	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earner/Two-Job Worksheet

Note: *Use this worksheet only if the instructions under line H on page 1 direct you here.*

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	**1**	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here	**2**	
3	If line 1 is **MORE THAN OR EQUAL TO** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter -0-) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	**3**	

Note: *If line 1 is **LESS THAN** line 2, enter -0- on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year end tax bill.*

4	Enter the number from line 2 of this worksheet	**4**	
5	Enter the number from line 1 of this worksheet	**5**	
6	**Subtract** line 5 from line 4	**6**	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	**7**	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	**8**	$
9	Divide line 8 by the number of pay periods remaining in 2000. For example, divide by 26 if you are paid every other week and you complete this form in December 1999. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	**9**	$

Table 1: Two-Earner/Two-Job Worksheet

Married Filing Jointly				All Others			
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $4,000	0	41,001 - 45,000	8	$0 - $5,000	0	65,001 - 80,000	8
4,001 - 7,000	1	45,001 - 55,000	9	5,001 - 11,000	1	80,001 - 100,000	9
7,001 - 13,000	2	55,001 - 63,000	10	11,001 - 17,000	2	100,001 and over	10
13,001 - 19,000	3	63,001 - 70,000	11	17,001 - 22,000	3		
19,001 - 25,000	4	70,001 - 85,000	12	22,001 - 27,000	4		
25,001 - 31,000	5	85,001 - 100,000	13	27,001 - 40,000	5		
31,001 - 37,000	6	100,001 - 110,000	14	40,001 - 50,000	6		
37,001 - 41,000	7	110,001 and over	15	50,001 - 65,000	7		

Table 2: Two-Earner/Two-Job Worksheet

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $50,000	$420	$0 - $30,000	$420
50,001 - 100,000	780	30,001 - 60,000	780
100,001 - 130,000	870	60,001 - 120,000	870
130,001 - 250,000	1,000	120,001 - 270,000	1,000
250,001 and over	1,100	270,001 and over	1,100

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